Clinical Psychology Forum

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I’m VERY PLEASED to be introducing this special issue on the relatively recent but rapidly spreading practice of team formulation, now seen as a key professional competence for clinical psychologists (Clinical Psychology Leadership Development Framework, Skinner & Toogood, 2010; Health and Care Professions Council standards of proficiency, 2009; British Psychological Society training accreditation criteria, 2010; Division of Clinical Psychology Guidelines on Formulation, 2011). It is also practised by some psychiatrists (e.g. Davenport, 2002; Summers, 2006; Martindale, 2007). Our regular BPS workshops (Cole, Dexter-Smith, Johnstone, Ingham and Milson is the current line-up) are always fully booked, and feedback suggests an enormous appetite for embracing this way of working.

It’s interesting to reflect on the reasons for this rise in popularity. Team formulation is not necessarily easy to introduce, facilitate or maintain within services, as the articles in this issue make clear. Practice-based evidence is accumulating, but hard facts and figures about its impact on recovery rates, use of medication, number of admissions and so on are not yet available (Cole et al., this issue). Nevertheless, once initial hurdles have been overcome, team formulation appears to be greatly appreciated by staff, and a number of benefits are claimed for it over and above the use of individual formulation (DCP, 2011). This should not be a surprise to clinical psychologists, for whom formulation is not just a useful technique but ‘fundamental to your own way of seeing the world’ as Dexter-Smith puts it in her article. Moreover, as Cole et al. point out, the development of explicit, structured, shared hypotheses for our work is the heart of evidence-based practice, and a formulation or hypothesis about the reasons for someone’s difficulties can be defined as ‘the lynchpin that holds theory and practice together’ (Butler, 1998, p.2).

My own experience suggests an additional reason for the enthusiasm for formulating in teams (Johnstone, 2014). Team formulation is the most powerful strategy I have found for shifting cultures towards more psychosocial models and understandings, in a way that reveals the person behind the diagnosis and allows individual stories to be heard. Staff in all specialties know, at some level, that narrowly medical interventions are at most a very partial answer, and are at worst actively re-traumatising. This is particularly true in mental health settings. Like many service users, staff too are looking for a different way forward. Team formulation can, at its best, offer just that, as many of these articles confirm. Specifically, it can provide the structure, containment and emotional support that enables staff to acknowledge the emotional pain and trauma hidden behind the labels (Clarke, Johnstone et al.). This allows us to take several steps along the road towards fully trauma-informed care – the emerging model which recognises that ‘the effects of complex (cumulative, underlying) trauma are pervasive, and if unresolved negatively impact mental and physical health across the lifespan’ (see www.asca.org.au; see also www.istss.org and www.traumacenter.org for many inspiring examples of trauma-informed systems and interventions).

The articles in this issue are organised in a rough order. An overview of the literature (Cole et al.) is followed by a description of the challenges of introducing formulation into services in the first place (Casares & Johnstone). There are a number of examples of successful projects from various specialties (Ingham, Clarke, Johnstone et al.), three of which are in the online extended version of this issue (Roycroft et al., Milson & Phillips, Lewis-Morton et al.) (www.bps.org.uk/cpf275). Dexter-Smith then reflects on the processes and politics of introducing team formulation across a whole service from the perspective of seven years on. Supplementary material such as audits and evaluation tools (Unadkat et al., Chiffey et al., Marshall & Craven-Staines) is also in the extended online edition.
Editorial

A number of other published projects had to be omitted because of lack of space, although most are mentioned somewhere in the reference lists. I am aware of many more in which evaluation is at an early stage, and I very much hope this collection of articles will inspire others to implement and write up further examples of team formulation work. Editing has been a pleasure, and I am grateful to all the contributors for their patience with my feedback. Please do send your comments, questions and responses.

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References
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Voluntary psychology graduate internships: Conveyor belt of exploitation or stepping stone to success?

I was interested to read Daniel Stevens and colleagues’ article ‘Voluntary psychology graduate internships: Conveyor belt of exploitation or stepping stone to success?’, where they proposed best practice standards for voluntary assistant psychologists posts. Many of their suggestions seemed entirely sensible but my attention was drawn to the guidelines for a time commitment of ‘at least two days per week and a maximum of three’. Presumably, part of the motivation for such guidelines is to ensure that the posts are not exploitative, but part also stems from the desire not to unfairly disadvantage those who do not come from wealthy backgrounds and are not able to work for free. One way of calculating this is to look at the National Living Wage which is currently estimated at £15,511 for a 38 hour week (£18,080 for Greater London) (Living Wage Foundation, 2015).

For someone outside London to volunteer three days a week and earn the living wage in the remaining two days per week, they would have to do a job that earned them a pro-rata annual salary of £38,777 (the equivalent of a high Band 7, entry level Band 8a qualified clinical psychologist). For someone to volunteer two days a week and earn the living wage in the remaining three days, they would have to earn a pro-rata annual salary of £25,185 (the equivalent of already working as an assistant psychologist or research assistant). In London these figures would obviously be even higher. Clearly, these are entirely unrealistic expectations that in effect still mean voluntary assistant psychologist posts would only be available to those who come from wealthy backgrounds where they are able to have their living costs subsidised.

However, limiting volunteer posts to one day a week would mean the post-holder would need to do a job in the remaining four days that earned the pro-rata equivalent of £19,389. This is possible with care assistant posts and is a reasonable expectation for a recent graduate.

Similarly, limiting voluntary assistant posts to one day a week would mean there would be more opportunities to go round, employers are less tempted to try and cover full-time posts ‘on the cheap’, and services offering voluntary posts are forced to cast a wider net for suitable candidates.

Voluntary assistant psychologist positions have been rightly identified as a source of exploitation and source of diminished diversity in our profession. Along with the other important suggestions from Stevens et al., an ethical voluntary assistant psychologist post should be limited to one day a week maximum to ensure that they are accessible to everyone who is able to obtain a graduate job.

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Reference
PSYCHOLOGICAL FORMULATION is a sense-making process conducted in collaboration with the client (DCP, 2011). The practitioner uses psychological theory to help draw links to possible interventions from the evidence base (Rainforth & Laurenson, 2014). The idea of working formulations in teams is by no means new (Bruch, 1998; Whomley, 2010). Team-based formulations, however, can take multiple forms; from verbally discussing therapy clients, ‘chipping in’ during meetings and informal discussions, to sharing letters and psychology reports (Christofides et al., 2012).

Team-based formulation groups can also take multiple forms, whether set up as reflective-practice groups or drop-in discussion forums, and whether arranged to discuss specific clients or as open-invite for discussing any clients or challenging situations (Hollingworth & Johnstone, 2014). Independent of the group format, attendance creates an opportunity to explore service user narratives and provides time to consider individuals’ experiences of working with clients. This opportunity for a psychological formulation that is developed collaboratively as a team is a valued component of such groups for attendees (ibid.).

Through engaging team members in hypothesising about someone’s difficulties, formulating in teams appears to help develop an explorative and inquisitive team culture (Johnstone, 2013). It may become the clinical psychologist’s role to facilitate openness to uncertainty and explore perceived challenges. They may wish to ensure such explorations remain fluid, tentative and defined in terms of an evolving formulation. Through paraphrasing and checking in with team members, the psychologist may facilitate the team to integrate the discussions into a coherent framework that reflects the contributions made.

Why involve pre-qualification members in addressing these issues?
When establishing groups based on formulating in teams, it may be useful to consider what role an assistant psychologist can play in implementation and delivery. For those early on in their careers with limited access to direct therapy contact, shadowing or assisting in formulating in teams may offer the perfect forum for developing knowledge of psychological assessment and formulation, fostering reflective practice through vicarious exposure to unique and complex scenarios.

The first author found team formulation groups a useful approach to building relationships within the team and getting to know how other staff members work. Formulating in teams invites alternative perspectives from others, and so it offers the opportunity to learn from our colleagues experienced in using different theoretical models and those from different professional disciplines. Similarly, this approach may be a helpful way to integrate into teams when placements or fixed-term contracts offer little time to build upon
working relationships with all team members. For example, these groups offer the opportunity for team members to familiarise themselves with the type of exploratory assessment questions that the trainee considers, with trainees demonstrating their competence in using psychological theory to make sense of complex situations in understandable and inclusive terms (i.e. avoiding jargon and not reinforcing pathologising discourse).

In busy working environments the clinical psychologist’s time may be limited, so at times the assistant or trainee may wish to help feedback learning or developments to the team on their behalf. Within challenging and complex environments, such as secondary community services, there may be the opportunity to develop skills in psychological leadership too. The first author found the Clinical Psychology Leadership Development Framework (2010) a useful tool to aid reflection on the benefits of implementing the group based on formulating in teams whilst in a pre-training role.

Using supervision to develop skills in formulation

With the appropriate support in place, it may be possible for pre-qualification members to contribute to the process of building formulations in teams. From their experience, the authors found a variety of approaches helpful in supporting pre-qualified members to plan and deliver these meetings:

- Attending referral-screening meetings may help pre-qualified members to develop initial assessment and formulation skills, particularly through exploring issues about risk.
- Having allocated time within supervision, not only to discuss the assessment and formulation of individuals, but also to consider wider systemic issues that address how a team may anticipate, react and respond to the needs of their clients.
- Using supervision as a forum in which pre-qualified members can explore but also be guided towards other relevant theories or perspectives that may aid and challenge the working formulation.
- Keeping a reflective diary to explore the different experiences in case formulation.
- Revisiting case notes following multidisciplinary team meetings to contextualise discussions and allow one to start thinking about what type of questions would be helpful to ask others when formulating as a team.
- Making plans to host review meetings with key-workers, to share and evaluate initial formulations collaboratively, and consider what would prove helpful in understanding the client’s needs.

The process of setting up team formulation groups

Both authors worked in an older persons community mental health team at the time of writing and, following a training session on using formulations in teams (Johnstone, 2013), looked at the possibility of implementing aspects of this within their team. The second author encouraged the first to consolidate his understanding of the topic by designing a CPD presentation for a local network of psychologists. He presented this with the hope of hearing about other people’s experiences of formulating in teams, asking what could be achieved locally and how.

Under supervision, the first author delivered training sessions on basic cognitive-behavioural therapy and formulation to the team. He hosted other shorter sessions, sharing formulation work he had done as part of this team, and trying to offer real and tangible examples of formulation in action.

As team-based formulation groups were novel to the team, the first author found it helpful to have a contextualised and structured example of how team-based formulations had been applied elsewhere. Jackman’s Shared Formulation Framework (Jackman, 2013) was used to explore this with the service manager during the planning stages, demonstrating where these groups could fit within the wider context of the service.

The authors facilitated the team to plan and organise when and where the groups would be held. Multidisciplinary team discussions were used by the team to select clients for discussion the following week at the formulation group. Attendees were also
able to bring other cases for discussion if they wished, requiring the facilitator to consider what could be achieved within that one session and what would need to be reviewed and brought back to subsequent meeting.

Our experiences from the initial groups
There were some challenges in setting up the team-based formulation groups. Initially, despite our utmost efforts, the team referred to the group as the first author’s ‘talk’, in which they were used to pre-qualified members delivering teaching sessions rather than facilitating case discussions. However, this perception of the group shifted as individuals attended the group and involved themselves in the discussions, moving the perception of the group towards a private and safe place to discuss our work openly.

The authors tried to build a sense of joint ownership of the groups by exploring what purpose they could serve for the team early on, and tried to encourage the team to make the practical decisions throughout (e.g. how to decide whom to discuss, and the frequency of groups). Through informal discussions, the authors explored how relevant the groups were for individual team members and emphasised the voluntary nature of attendance and participation. This may have allowed for the group not to be viewed as ‘another talk’ and encouraged individuals to attend if they felt it was appropriate and relevant to them.

The first author had set the group up with pens and paper in anticipation of the team all contributing from the start of the group. The reality was very much different when a colleague walked in to utter the words, ‘Oh, we don’t actually have to do any writing or work, do we?’ The authors anticipated future groups would involve team members in drawing up formulations together, but appreciated that this engagement in the group may develop over time.

By the fourth meeting there were regular attendees and many individuals participated in formulating cases through questioning and discussion. The authors were able to process and make sense of why the team found certain experiences difficult to deal with. The team started to explore why individuals may present in certain ways; building psychological frameworks for understanding these difficulties and developing plans originating from discussions together as a team.

The team formulation groups are ongoing and have now been running on a weekly basis since mid-late 2013. Older Adult psychological services have implemented team formulation groups across multiple teams to date and are currently making plans to introduce team formulation groups to inpatient settings for those diagnosed with dementia that present with behaviour that challenges.

Concluding thoughts
Establishing a model of working formulations in teams encourages much more than just sense-making. It offers the pre-qualified individual the chance to experience and develop key competencies, such as leadership and consultation skills. Team formulation groups open up dialogues that acknowledge different perspectives and feelings within a team. Ultimately, we feel that these discussions encouraged a greater appreciation of team dynamics and their impact on our clients, fostering person-centred values and non-pathological understanding. This can be an excellent opportunity for the pre-qualified member of the team to help shape service delivery.

Writing on leadership, Steve Onyett spoke of our head, heart and hands aligned in goal seeking behaviour (2012). Perhaps the team-built formulation consists of the perfect composition: the theoretical heads, the empathic hearts, and the hands of all those involved in the person’s care.

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References


Understanding Psychosis:
Developments a year on from the release of the document and strategies for dissemination

BPS London Office, 30 Tabernacle Street, London EC2A 4UE
Wednesday 11 November 2015, 9.00am–4.00pm

By the time of the conference it will be nearly a year since the launch of Understanding Psychosis and Schizophrenia, a report published by the DCP and edited by Anne Cooke. The day will focus on an overview of the document, developments a year on from publication, how it has been used in practice, and strategies for dissemination of the information contained in the report.

This is a free event for Faculty of Psychosis and Complex Mental Health members, service users and carers only. Prior booking is required.

If you have any queries, please e-mail MemberNetworkServices@bps.org.uk, with ‘PCMH–Psychosis–Nov15’ in the subject line.

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Ethics Column

To formulate or escalate? Ethics and how to respond when relationships break down between NHS services and residential care providers

Katy Lee & Nan Holmes

This article considers how clinical psychologists might respond when relations break down between NHS services and residential care providers. We reflect on times when we may choose to formulate such ruptures or instead decide to escalate concerns (guided by the principles outlined within the Society’s Code of Ethics and Conduct (BPS, 2009)).

As CLINICAL PSYCHOLOGISTS working within NHS community teams, we have become aware of some of the complex ethical issues that can arise when providing services to clients living in residential or nursing homes. There are concerns within community teams that raising safeguarding alerts about a culture within an organisation may jeopardise the future working relationship between that care home and the team. While staff members are aware of their duty to act responsibly, how is the ‘fall-out’ to be managed and what can psychologists contribute? We have been considering when we might wish to formulate these systemic difficulties and when we feel the need to escalate concerns about practices or cultures that exist within external agencies. While we explore this issue by focusing on relations between private care providers and NHS services, such dilemmas have application to varied situations where more than one team are involved in the care of the same client.

The changing NHS context
Following the introduction of the coalition government’s Health and Social Care Act (2012), NHS services have faced increased competition for contracts as well as a greater need to network with care providers who have successfully obtained Any Qualified Provider status. The Act also enabled a significant increase in the amount of non-NHS income that foundation trusts can earn (with private revenue being capped at 49 per cent, rather than 2 per cent). On a local level, these policy shifts have led NHS trusts to explore income generation opportunities, such as training initiatives. Furthermore, our experience has been that there is increasing pressure for all providers (spanning both private and public sectors) to claim ‘expert’ status and the necessary credentials to impart their skills onto others. In some circumstances, the competition between services means that agencies can feel under pressure to claim more expertise than they actually possess. This could result in an unwillingness to seek help about clinical issues or defensiveness about the practices that exist within a given organisation.

The care provider context
As psychologists, we have a firm grounding in social psychological processes but how often do we pause to consider the way in which an ‘us and them’ culture might be influencing our work? This is especially true when working with residential or nursing homes, which frequently face unenviable pressures such as high staff turnover, unrealistic tariffs and stringent financial directives. However, before continuing, it is also important to highlight that there are many
exceptional residential care providers who successfully navigate these obstacles and deliver outstanding care. It seems that NHS services could learn a great deal from these agencies and perhaps the increased need for networking will enable us to do so.

Nevertheless, we must remember that the majority of nursing/residential homes are businesses, and hence much attention is paid to propagating a positive image and reputation. This means that a conflict can exist between wanting to deliver high quality client care whilst attaining targets and financial outcomes set by the organisation (Loveday, 2012). A mismatch may occur between desired and actual care delivery, which will inevitably generate uncomfortable feelings in care home workers or managers. When faced with this inner conflict, harmful social psychological processes are more likely to occur and it may be tempting to project blame or difficult feelings onto others.

Given these challenges, interactions between NHS services and residential care providers can sometimes be akin to ‘walking on eggshells’. As psychologists, it can be difficult to judge when reparative interventions are indicated or when concerns need to be escalated. This is particularly true for situations where no clear safeguarding breach has occurred but reservations are held about the culture or leadership style within a given organisation. An example of this ‘grey’ area might include interfacing with care providers who have high staff turnover or over-utilise agency staff. Such organisational issues might mean that it is difficult for NHS professionals to gain clarity about the service user’s life history and current problems, making it difficult to implement a meaningful ‘action plan’.

Understanding relationship dynamics using cognitive analytic therapy

Our experience is that there can be times when interactions between NHS professionals and nursing/residential home managers can reflect highly defended positions (in these services, but also within our own teams). Drawing on ideas from cognitive analytic therapy (Ryle, 1991), it can be useful to consider the typical ‘reciprocal roles’ that can be enacted when there are pressures, competition or tensions between services. Reciprocal roles are defined as a ‘stable pattern of interaction originating in relationships with care-takers in early life, determining current patterns of relationships with others and self-management’ (Ryle & Kerr, 2002, p.220). Applying these ideas to interactions across networks, a common reciprocal role can include professionals adopting the position of a wise, knowledgeable and superior sage who splits people around them into two groups: a contingent of fellow ‘experts’ and those who are deemed ‘incompetent’. It often becomes apparent that people occupying these ‘all knowing’ roles (along with their allies) are very powerful and possibly even feared by members of their team.

By becoming firmly wedded to a position of superiority, individuals can become highly sensitive to perceived criticism from outside agencies. In circumstances where managers from residential homes model such interactions, they may quickly feel threatened by NHS professionals and hence struggle to reflect on how their behaviour could be affecting the delivery of client care. This may cause the manager to resist interventions or suggestions offered by NHS services (since they believe they already possess all the answers) or to only participate in conversations in a superficial way (for example, over-emphasising the positive practices within their care facility).

In such situations, professionals working for local NHS services may pose a threat to the reputation or financial viability of residential care providers, and this can cause serious ructions to develop. For example, if safeguarding issues are raised, or perhaps reports or reflections are not wholly complimentary, then managers may feel wounded, ashamed and attacked by NHS services. As psychologists, we also need to be mindful of our temptation to be drawn into these powerful relationship dynamics: perhaps by claiming ‘expert’ status or being tempted to react if we are made to feel incompetent or ‘not good enough’.

Whether we or care home managers occupy a superior position, it is clear that this role is unsustainable and we cannot remain ‘all knowing’ forever. When gaps inevitably become
apparent in the ‘superior’ person’s knowledge base, this can activate a dreaded or feared role (criticising/attacking – criticised/attacked), causing external agencies to be denigrated or rejected. This could lead to individuals from outside agencies (or indeed the whole team) being criticised by representatives within the care facility, or services feeling too ashamed or wounded to seek help. Such a description refers to the endured position that often exists between services (rejecting/distancing – rejected/cut-off) and perhaps we can be guilty of accepting this avoidant status quo when confronted with hectic work schedules. However, over time, relationships between services become increasingly strained, which causes client care to suffer. Accordingly, our experience tells us that we should be equally concerned about nursing/residential homes that seem disconnected from services as those who persistently seek support or guidance from NHS services.

When to formulate and when to escalate?

The previous section considered the use of cognitive analytic therapy to illuminate some common dilemmas encountered when relations break down with residential care providers. However, in what circumstances do we try to explore these powerful dynamics and when do we need to escalate concerns to regulatory or commissioning bodies? Of course, the answer is obvious when we hold clear safeguarding concerns, but what should we do when residential care providers fail to cooperate with our interventions or ideas (for example, failing to complete observational charts or implement care plans devised in partnership with NHS services)? Other dilemmas might involve home managers refusing to circulate reports that are not wholly complimentary about their organisation, or holding grudges against community team members who have raised a safeguarding alert. When navigating such issues, we hope the following ideas might be helpful.

If the recipient is willing, tentatively map the relationship dynamics; otherwise, try to model behaviours that challenge the status quo.

One solution to these dilemmas would be to co-construct a formulation with the person involved in the relational rupture. As psychologists we tend to possess a high level of curiosity about processes that exist within services and this can encourage us to want to share our reflections with our colleagues. However, we cannot assume that the recipients of such discussions wish to do the same, and we therefore need to carefully assess the person’s willingness before rushing in.

Trying to open up such a dialogue might be destabilising for individuals who are occupying heavily defended positions, and hence it might be more appropriate for the psychologist to hold the formulation in mind and try to modify their own behaviour. It is worth highlighting that such interactions commonly require psychologists to tolerate a great deal of frustration, since this could involve modelling vulnerabilities and insecurities which are not shared in return (for example, acknowledging times when the psychologist has felt incompetent, deskilled or overwhelmed by complexity). However, it may be that when working with some residential care providers, simple rapport building techniques (such as distancing oneself from an ‘expert’ position and showing a genuine interest in your colleagues’ values and work stressors) are sufficient in repairing broken bonds.

Utilise peer supervision to raise awareness of the challenges faced when working with external agencies and discuss concerns with senior managers or clinicians

When faced with such complexity, it is important that professionals are able to share and process their (appropriately anonymised) experiences and doubts. Reflective practice meetings, peer supervision and ethical panel discussions might help to raise awareness and develop appropriate individual or service responses to such dilemmas. When engaging in these dialogues, it is helpful to review the four component model of ethical conduct devised by Rest (1982). This framework, which is included in the Society’s guidance on teaching and assessment of ethical competence in psychology education (BPS, 2015), considers clarifying/identifying ethical issues (ethical sensitivity), exploring the rationale for a given course of action (ethical reasoning), being motivated to act ethically (ethical
motivation) and executing the agreed plan (ethical implementation). This model highlights the need for clinicians to reflect on various dilemmas, motivations and possible enactments before a decision is made about whether to respond by formulating or escalating concerns. Such decisions are also informed by the individual’s leadership capacity, ability to prioritise and explore dilemmas, and risk management concerns (BPS, 2015).

The British Psychological Society’s Code of Ethics and Conduct (2009), with its focus on ethical decision making, can serve as a useful structure for such discussions. It advises that after ‘identifying relevant issues (and) reflecting upon established principles, values and standards’ (p.15) to use the Code ‘to identify the principles involved (and) develop alternative courses of action in the light of contextual factors’ (p.15–16). Each of these possibilities should then be analysed by weighing up ‘the advantages and disadvantages of various courses of action for those likely to be affected, allowing for different perspectives and cultures’ (BPS, 2009, p.16) before one is chosen. Subsequently, the Code recommends evaluating the outcomes to inform future ethical decision making.

In circumstances where initial attempts at conflict resolution prove unsuccessful or where recurring difficulties exist between agencies, it may be necessary to involve senior managers. While it could be argued that this tactic will only fuel mistrust, professionals directly linked with the rupture could be too emotionally invested to personally intervene. If the issues pertain to culture or poor engagement with services, it may be helpful to converse with local safeguarding leads or raise low-level concerns with quality assurance teams. These professionals might decide to convene a network meeting or can provide advice about whether any additional action is warranted. Finally, local NHS guidelines about when to suspend or cease working with residential care providers could be established to promote a consistent response to this ethical dilemma.

**Highlight concerns with commissioning or regulatory bodies**

If the aforementioned strategies fail to resolve concerns about the culture or engagement of a given care home then further action will need to be taken. Such interventions may have major implications (for both the care provider and their relationship with local NHS services), and so should only be considered when significant difficulties remain unresolved. At this stage, NHS professionals will need to share their opinion with the Care Quality Commission (CQC) that the care provider is unable to meet a client’s needs because of their unwillingness to interface with services.

In relation to this point, the CQC stipulate 16 core standards which care providers are benchmarked against, and the sixth of these relates to ‘co-operating with other providers’ (CQC, 2010). Accordingly, there is an expectation that care providers ‘so far as reasonably practicable, work in cooperation with others to ensure that appropriate care planning takes place’ (NHS England, 2010, p.82).

The document also states that providers should allow clients to ‘access other health and social care services or support relevant to their care, treatment and support needs, provided that their care, treatment and support will not be compromised’ (CQC, 2010, Standard 61, p.87). Such directives clearly emphasise the need for residential care providers to network with other agencies and therefore NHS professionals are well within their rights to offer feedback to CQC representatives about their perspectives.

**Conclusion**

In summary, psychologists frequently encounter ethical dilemmas when working with clients who have complex needs and these can lead to disputes or disagreements between agencies. While our profession is well equipped to understand how the actions of both ourselves and others can perpetuate such conflicts, our fundamental responsibility is to protect clients by acting in accordance with professional codes of conduct and safeguarding policies. Formulating relationship dynamics may be very helpful when working with organisations that are prepared to tolerate this intervention; however, more serious steps need to be taken when reparative work proves unsuccessful.
Psychologists have an important role to play in supporting team members who are navigating systemic ruptures, by fostering understanding about why such interactions have occurred. As a profession, we should also be striving to create spaces where we can safely explore the dilemmas faced when working across multiple systems. This could be achieved by providing reflective practice sessions or through the establishment of robust peer support networks to facilitate responses to the ethical issues faced in our work.

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References
TEAM FORMULATION refers to the process of facilitating a group or team of professionals to construct a shared understanding of a service user’s difficulties. It provides a structured way to integrate information from members of a multidisciplinary team (MDT) and generate hypotheses to inform intervention planning (Johnstone, 2014).

As described in the editorial, team formulation appears to be gradually gaining acceptance as an integral part of clinical practice. However, its process, impact and utility are under-researched. Furthermore, the systems and support that appear to be needed for this kind of work may not be generally available (Jackman, 2013). Casares and Johnstone, Chiffey et al. and Dexter-Smith (this issue) have described the large-scale systemic changes that are needed if formulation is to be integrated into all levels of the service. It is not surprising, therefore, that team formulation is most commonly reported as occurring only within specific teams, or at specific points in the care pathway, perhaps with more complex and longer-term service users (e.g. Summers, 2006; Hewitt, 2008).

This paper reviews a comprehensive range of literature on psychological formulation with teams. It draws on unpublished literature as well as peer reviewed publications due to the relative newness of the field. The review is organised around five broad questions, which reflect the debates about formulation in general (Johnstone, 2014):

1. Why formulate with teams?
2. Is team formulation useful, and if so, in what ways?
3. How do staff experience team formulation?
4. How do service users experience team formulation?
5. What are we (or what should we) be doing when we formulate with teams?

Why formulate with teams?
Many researchers and clinicians have argued that the use of psychiatric diagnoses as a basis for understanding and treating mental health problems lacks reliability and validity and fails to adequately acknowledge the influence of wider psychosocial factors (e.g. Bentall, 2009; Boyle, 2002). It has been argued that psychological formulations provide a more holistic and individualised understanding of the development and maintenance of service users’ difficulties (Johnstone & Dallos, 2014), and as such might be expected to lead to more person-centred and effective intervention packages. With the increasing demand for psychological skills to be made available to more people at a lower cost, developing formulations with other members of multidisciplinary teams (MDTs) is one way in which psychologists have sought to make the most of their limited resources (Onyett, 2007). It has also been claimed that team formulation is an effective way of shifting MDT cultures towards more psychosocial perspectives (DCP, 2011), increase awareness of the causal role of trauma and adversity (John-
stone et al., this issue), and generally enable more open discussion of different conceptualisations of mental health (Onyett, 2007).

It should be noted, however, that as with individual formulation, practice has outstripped the (so far) limited research base for these claims.

Is team formulation useful, and if so, in what ways?

The general literature on formulation suggests that it performs numerous functions, including: providing a systematic framework for hypothesising about problems (Eells, 1997); helping to prioritise issues (Beck, 1995); overcoming biases (Butler, 1998); rendering the client’s problems understandable and predictable (Mears & Dryden, 1990); aiding the working alliance (Wills & Sanders, 1997); pre-empting difficulties (Ryle, 1990); ensuring that interventions are ‘meaningful’ (Evans & Midence, 2005); and generating effective, needs-based care coordination, sensible service planning and optimising risk assessment (Pilgrim, 2000). These benefits are expected to apply to team formulation as well, along with the additional perceived advantages of improving communication and teamwork, drawing on and valuing the skills of different professions, and increasing team understanding, empathy and reflectiveness (DCP, 2011).

There are ambiguities and contradictions in the general literature on formulation about how to assess its ‘accuracy’ and the implications for research agendas (see, for example, Butler, 1998, pp.20–21). The small body of studies that have attempted to establish whether formulations are based on reliable inferences and valid constructs have attended to different theoretical assumptions and adopted varying ways of ‘operationalising’ these questions. Consequently, the evidence for the reliability and validity of formulation is not well established in general (Chadwick et al., 2003; Kuyken et al., 2005); and indeed the question of what sense of ‘validity’ is relevant to a shared narrative account of an individual’s life has not been resolved.

Interestingly, the emerging consensus from the above studies is that whilst the reliability of formulations is compromised as clinicians move from descriptive to inferential levels, this is ameliorated in groups of trained formulators. It seems that groups may collectively bring a greater range of available data and/or provide a balance against the use of interpretative errors that adversely affect clinical judgment, such as representativeness (Tversky, 1977) and framing and availability biases (Kahneman, 2003). This might indicate that team formulations should be more reliable than those developed by a single clinician.

Team formulation, as with all formulation, could in principle be reliable and valid but have no impact on outcome; conversely, it could be unreliable and invalid but lead to improved outcomes. This has led some to argue that formulation is best assessed in terms of ‘usefulness’ (Butler, 1998). The ‘case formulation hypothesis’ states that, all else being equal, outcomes should be better for service users whose care is based upon an individualised formulation than for those without (Persons, 1991). A recent study focused on the reliability and validity of formulation-based treatment planning rather than the formulations themselves (Dudley et al., 2015). It found that when provided with a comprehensive formulation, clinicians of all levels were able to make appropriate treatment choices, but that this benefit was reduced when the formulation was developed by novice clinicians.

In an unpublished study, Hull et al. (2015) argued that team formulations significantly influenced the content of care plans in older adult mental health inpatient units, leading to documents that conveyed a greater sense of the individual and more meaningful recommendations in relation to building and maintaining safety, independence, responsibility and relationships.

However, articles in this issue, as well as a follow-up audit by Walton (2011) and a service evaluation of team formulation meetings in a community mental health team (Allen, 2015) report that the recommendations from formulation meetings may not always be carried out, suggesting that further work is needed to ensure that formulations are actually used to inform interventions.
Future research could test the utility of team formulations by comparing intervention plans and outcomes for service users randomly assigned to team formulation-driven interventions as opposed to treatment as usual. This would still leave open the question of whether changes were due to the team formulation per se, to the intervention as a whole, or to mediating factors such as changes in team-service user interactions.

One study has attempted to investigate this by using a cluster-randomised trial with a sample of 51 patients and 85 staff to compare wards using weekly team formulation meetings to treatment as usual over a period of six months (Berry et al., 2009). The intervention group showed improvements in staff-patient relationships and reduced staff burnout. Feedback interviews suggested that the intervention was acceptable, increased staff understanding and resulted in changes in practice. Although the study was not fully powered in relation to patient outcomes, there was evidence of improvements in patient problem behaviours. Due to the promising results of this pilot study, a multi-centred randomised-controlled trial is being planned.

**How do staff experience team formulation?**

Small-scale studies and evaluations have suggested that team formulation meetings may be beneficial for team working in several ways, which may in turn benefit the care received by service users, by: increasing staff satisfaction; improving team functioning in terms of drawing together information and ideas; and facilitating the collaborative generation of psychologically informed suggestions for care planning (Allen, 2015; Chiffey et al., this issue); Graven-Staines et al., 2010; Hollingworth & Johnstone, 2014; Lewis-Morton et al., this issue; Roycroft et al., this issue; Summers, 2006; Wainwright & Bergin, 2010). Staff in Allen’s small-scale service evaluation claimed that team formulation ‘...helps the team bond and bounce off each other’ and ‘...creates team ethos and support’ (Allen, 2015, p.17). Evaluation of formulation meetings by Unadkat et al. (this issue) found that staff appreciated recognition and validation of their work, the opportunity to slow down and think about clients in a deeper way and increased understanding of the client’s issues – although they struggled to identify more tangible benefits for the client and impact on practice. Maguire (2006) reported that training and supervision in cognitive behavioural formulation led to improvements in perceived self-efficacy and helpfulness among staff working with the homeless. Similarly, an evaluation of the effectiveness of twelve team formulation meetings within a community mental health team found that staff members’ perceptions of ‘stuckness’ with a client significantly reduced as a result of team formulation (Allen, 2015; p < 0.05).

Staff responses in all these studies were very positive overall; for example, the respondents in one study (Hollingworth & Johnstone, 2014) strongly endorsed all the hypothesised benefits of team formulation listed in the DCP guidelines (2011) and made comments such as: ‘I found the team formulation meeting was most helpful in helping me to have a greater understanding of the service user’s condition and provided me with reasons for her behaviour’ (p.32). The Team Formulation Questionnaire developed by these authors is now being used to evaluate staff attitudes in the services of other contributors to this issue (e.g. Milson, Cole).

MDT staff in Hood and colleagues’ study (2013) made statements such as: ‘[Formulation] really, really was useful and I think just to have the head space to really think about what was happening.’ (p.113), along with expressing some lack of confidence in formulating without support from psychologists. Summers (2006) used grounded theory to analyse staff views of team formulation meetings in a high-dependency rehabilitation setting. Staff made comments such as: ‘One of the most productive things on the ward’, and: ‘Afterwards the problems
seemed understandable, something we could start to address’ (p.342). A minority expressed reservations about formulations being too speculative and felt that incorrect conclusions could be drawn on the basis of little information.

These studies make an important start in developing our understanding of psychologists’ and MDT staff views of team formulation. However, they used small samples (5–30 participants), which is likely to limit the generalisability of the findings. It is possible that some of the suggested benefits of team formulation are due to factors other than the formulation itself; for example, increased team contact and opportunities to consult with each other (Hollingworth & Johnstone, 2014). However, if having the space to reflect upon cases and team processes is something that is seen to be valuable in itself (Onyett, 2007), team formulation meetings may provide an opportunity which is often missing from overstretched services. Further substantiating research is clearly needed to establish whether the perceived benefits of team formulation are realised in practice.

How do service users experience team formulation?
To date, there is no research into service users’ subjective experiences of care from teams that have developed a formulation for them, or of the team formulation process itself. The issue of whether, how and when to involve service users in the process of team formulation has been the subject of discussion by several authors (e.g. Wainwright & Bergin, 2010; Whomsley, 2010) and is addressed by several of the papers in this issue (Casares & Johnstone; Chiffey et al., Ingham; Johnstone et al.; Lewis-Morton et al.; Milson et al.; Roycroft et al., p.XXX). A minority of the papers identified in this review stated that they had obtained the informed consent of service users for their cases to be discussed by the team (e.g. Hewitt, 2008; Kennedy, 2008). Some authors have reported attempts to involve service users and carers in team formulation meetings – although they have also identified that this has not occurred as much as it possibly should (e.g. Craven-Staines et al., 2010). Milson and Phillips have reported (this issue) some encouraging responses from adolescents in a Tier 4 child and adolescent mental health service inpatient unit to having team formulations shared with them. There has also been a description of an approach to sharing team formulations with people using a learning disabilities service (Ingham, 2012).

If team formulation is viewed as a kind of staff supervision or consultation then it would not necessarily be considered appropriate to share all aspects of it directly; for example, the parts that formulated strong staff counter-transference feelings (Johnstone, 2014). However, the general principle of collaboration suggests that service users and/or their carers should be aware of formulations and have the opportunity to give feedback on both the content and the process of team formulation. Qualitative data from structured interviews suggest that service users may have mixed reactions to individual formulation (Evans & Parry, 1996; Morberg Pain et al., 2008). This implies that very careful consideration should be given to making the feedback process as sensitive as possible; indeed, deciding how to do this can be seen as an essential aspect of the team formulation discussion (Johnstone, 2014).

What are we (or should we be) doing when we formulate with teams?
Christofides and colleagues (2012) explored how clinical psychologists applied psychological formulation to their work in MDTs. The practice seemed often to have developed organically through a process of trial and error, whereby ‘chipping in’ aspects of an independently derived formulation to team meetings moved tentatively towards a more explicit use of collaborative formulation with staff. From the practice-based evidence literature, it is clear that some psychologists have gone on to develop more consistently structured means of using formulation in teams (see Davenport, 2002; Kennedy et al., 2003; Lake, 2008; Whomsley,
These approaches vary in setting, duration, therapeutic modality, structure and the extent to which they were transparent to the service user.

None of these models have been formally evaluated, although some recommendations for practice emerge that could be empirically tested:

- team formulation might be most effectively done separately from existing meetings, at a dedicated time (Christofides et al., 2012; Whomsley, 2010);
- facilitation of the meetings should be shared amongst team members (Hewitt, 2008; Johnstone, 2014; Kennedy, 2008; Whomsley, 2010);
- a co-facilitator who is able to attend to the group process helps to keep the meetings focused and effective (Johnstone, 2014);
- training may help to ‘socialise’ staff to the approach (Davenport, 2002; Dexter-Smith, 2010);
- supervision may help to sustain those skills (Kennedy, 2008; Summers, 2006);
- formulation may have the most to offer if it is embedded in routine practices with robust links to care planning (Summers, 2006); and
- formulations should be typed up immediately after meetings and placed in service users’ files to increase the effectiveness of the recommendations arising from them (Whomsley, 2010).

The general literature on formulation has emphasised the need to engage in a process of ‘evolving formulations’, which develop incrementally from basic description to complex inferences (Kinderman & Lobban, 2000). At any stage, the formulation should be considered provisional: ‘formulation thus goes hand-in-hand with reformulation’ (Butler, 1998, p.22). However, only Whomsley’s article (2010) addresses the practice of reformulation, through team formulation review sessions in his model, so its role and significance in team formulation is still largely unclear. The reflection tool (Marshall & Dexter-Smith, this issue) for promoting good practice in facilitating team formulation by providing a framework to support the governance of the process, regardless of the model utilised, may help to address this gap.

**Conclusions and future directions**

Evidence-based practice is the integration of clinical expertise, patient values, and the best research evidence into the decision making process for patient care. Clinical expertise refers to the clinician’s accumulated experience, education and clinical skills. The patient brings to the encounter his or her own personal preferences and unique concerns, expectations and values (Sackett, 2002). Interestingly, this could also be taken as a definition of formulation itself, which has been described as having the clinical skill to ‘combine… psychological theory/principles/evidence on the one hand, and (the client’s) personal thoughts, feelings and meanings on the other… in order to develop a shared account that indicates the most helpful way forward.’ (DCP, 2011, p.7)

Arguably then, formulation can be seen as a framework or process for implementing the basic principles of evidence-based practice: ‘A formulation is the tool used by clinicians to relate theory to practice.’ (Butler 1998 p.2). From this perspective, arguing against the use of formulation per se is tantamount to saying that therapists and teams should not develop explicit, structured, shared hypotheses about service users’ difficulties. However, there are legitimate and so far under-researched questions about the efficacy and acceptability of formulation as a specific way of developing such hypotheses (both with individuals and teams).

The generally very positive feedback from MDT staff who have participated in team formulation derives from small studies that need larger-scale replication. Similarly, the majority of the peer reviewed literature relates to adult and older adult inpatient or rehabilitation settings. Moreover, we know very little about which formats, models and strategies work best in which settings.

The current lack of literature on service user perspectives on team formulation is a gap that remains to be filled. In order to max-
imise its benefits and minimise potential damage, we need to clarify whether and in what ways service users find team formulations, or the interventions that follow from them, helpful and acceptable. This might best be done by a programme of predominantly qualitative research.

Future research might attempt to establish whether team formulations have construct and convergent validity by using triangulation methodologies. These might include service users’ own ‘formulations’ or their assessments of whether team formulations map onto their own understandings, as well as formulations developed solely by psychologists. Future research could also usefully try to establish whether team formulations have predictive validity; for example, by assessing the extent to which they account for problems encountered later in MDT care of service users.

The most powerful evidence, from the point of view of managers, commissioners and service leads, would relate to whether team formulation helps to achieve specific outcomes such as better recovery rates, reduced use of medication, fewer admissions and so on. One might expect that a tailored, evidence-based intervention plan based on a detailed consideration of a particular individual’s needs would increase the likelihood of achieving these goals. Equally, one might anticipate that since staff-service user relationships are a key predictor of recovery and relapse (Berry et al., 2011), anything that increased staff empathy and understanding would also promote such outcomes. To date, no study has yet attempted to demonstrate this.

It has been argued that, especially in the field of therapy, evidence-based practice should be complemented by practice-based evidence (Barkham & Mellor-Clark, 2000); in other words, generating an evidence base through a ‘bottom-up’ process based on routine clinical practice. The growing popularity of team formulation provides an ideal opportunity to produce this knowledge via practice-based networks. In the meantime, clinical psychologists should adopt a cautiously optimistic attitude to team formulation while working to fill the gaps in our knowledge.

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Integration of formulation in adult multidisciplinary services across a large NHS foundation trust – Phases 1 and 2: Training and integration

Philippa Casares & Lucy Johnstone

This article summarises an ambitious project to embed formulation into the care pathway of a redesigned adult and later life secondary care community service. We describe the initial training package and follow-up, and reflect on further areas for development.

Three years ago, beginning in 2011, the adult and later life secondary care community services in Sussex Partnership NHS Foundation Trust underwent a complete redesign and transformation. Previously they consisted of a large number of multidisciplinary recovery services (including team psychologists) and separate psychological therapy services. During 2011 and 2012 these merged into age-integrated, single point of access multidisciplinary team (MDT) services that have been re-housed and re-organised into eight specialist assessment and treatment community centres across Sussex: Hastings, Eastbourne and the Weald, Brighton, Hove, Worthing, Chichester, Mid Sussex and Northern.

The aim of this new design (known locally as ‘Better By Design’ and ‘Under One Roof’) was to create more effective, resource efficient, high quality assessment and treatment centres that would ensure service users were receiving the best possible evidence-based care, utilising the skill mix of the teams in the most effective way.

In order to support these new services to deliver effectively, a new training strategy was developed. Clinical psychologists in the strategy group identified the need for increasing skills in formulation, in order to integrate formulation into a restyled multiprofessional assessment service.

Formulation had of course been a feature of many of the services before the redesign, and some pockets of Sussex Partnership had excellent practice and models (Lake, 2008). But it was not consistent across the Trust and was not integrated in any formal way into a service model. Formulation was also largely owned by psychology and not seen as everyone’s business. The development of new services seemed an excellent opportunity to promote the practice of formulation as a means of developing focused, robust and evidence-based approaches to assessment and intervention, and bring the new teams together to build on existing formulation skills. At around this time, fortuitously, the DCP produced the Good Practice Guidelines on the Use of Psychological Formulation (DCP, 2011). Philippa Casares, Consultant Clinical Psychologist, was appointed to design and lead a project on training and development of formulation practice in the new services.

The overall aims were to facilitate the development of individual and team formulation skills for all MDT staff, and to embed a psychobiosocial approach to formulation. It was intended that every service user should have a formulation as a basis for drawing up the most appropriate individual care package, and that would be easily identifiable in the notes.

There were three phases to this project: (i) training of staff; (ii) embedding formulation...
within the new services; and (iii) evaluation. The first two phases are described below.

Training of staff: The plan
1. As Hastings was one of the first sites to move ‘Under One Roof’ it was chosen as a pilot site. Philippa Casares set up a core MDT Practice Development Group to oversee the whole project, consisting of herself and an occupational therapist, a nurse and a psychiatrist. Lucy Johnstone, consultant clinical psychologist and lead author of the DCP’s *Good Practice Guidelines on the Use of Psychological Formulation* (2011), was invited to consult with the group and develop a training package on formulation for clients at first point of contact with the service, as a basis for subsequent care planning. It was also agreed that staff would be trained in team formulation to support good practice in ongoing intervention, especially for more complex cases.

2. The two training packages were initially delivered to the Hastings MDT service in two half-day sessions in March 2012 and June 2012. The first session ‘Formulation at Initial Assessment’ covered basic training in formulation and how to begin formulating from referral letter through to assessment. The second session ‘Formulation in Teams’ built on the first and looked at developing shared team formulations and facilitating team formulation sessions. Evaluation showed that both these sessions were well received, and the Training Department agreed to support roll-out to all 320 staff working in the new assessment and treatment services across the Trust.

3. In order to ensure local ownership, Philippa Casares worked with a multidisciplinary group of ‘Formulation Champions’ in each of the new sites. Their role was to take a lead on the project within their teams, set up MDT practice development groups in each assessment and treatment service in order to oversee the roll-out of the training and support subsequent integration into the new service model.

Lucy Johnstone came to Sussex Partnership NHS Foundation Trust for one week in March 2013 to deliver the half day ‘Formulation at initial assessment’ package on eight occasions. By pairing up the eight local sites and running repeat sessions morning and afternoon, all staff were potentially able to attend. She returned for a week in June 2013 to deliver ‘Formulation in Teams’ sessions to the local sites, using the same 8 x half-day format. She also delivered a half-day session for potential facilitators of team formulation meetings.

The results from the before-and-after evaluation forms are summarised below.

**Results**
- 240 MDT staff across the Trust attended the ‘Formulation at Initial Assessment’ session.
- 273 MDT staff across the Trust attended the ‘Formulation in Teams’ session.
Figure 1: How do you rate your current knowledge of formulation?

![Chart showing the number of people rating their knowledge of formulation before and after a workshop.](chart1)

Figure 2: How relevant do you think this training will be to your clinical practice?

![Chart showing the number of people rating the relevance of training before and after a workshop.](chart2)
Figure 3: How confident are you in using formulation in your clinical practice?

![Confidence in Formulation Chart]

Figure 4: How would you rate your knowledge of formulation?

![Knowledge of Formulation Chart]
The majority of these staff were from the new assessment and treatment services, but a few came from elsewhere (e.g. acute and specialist services). It was recognised that the training might need to be adapted and delivered to the acute services as well, and we are aiming to do this in 2015.

Some 61 per cent of the Part 2 attendees had attended Part 1 (i.e. 166 MDT staff attended both training events); 74 attended just Part 1 and 107 attended just Part 2.

Overall, 181 staff attended at least one of the training sessions. Table 1 gives a breakdown of attendees by discipline.

The timing of the training at the beginning of the new service model meant that it functioned in part as a form of team development, and 90 per cent of attendees said that it was helpful or very helpful to train as an MDT. It was also hoped that this would help to embed an MDT approach to formulation from the start.

Figures 1–3 show the reported changes in knowledge about formulation, confidence in using formulation, and perception of relevance to clinical practice for staff attending the training on ‘Formulation at Initial Assessment’.

Figure 1: 80 per cent of attendees rated their knowledge of formulation as good or very good post workshop compared to 31 per cent pre workshop. Only 9 per cent said they had no knowledge pre workshop.

Figure 2: 89 per cent rated the content of the training as mostly or very relevant to their clinical practice post workshop compared to 67 per cent pre workshop.

Figure 3: 65 per cent rated their confidence in using formulation in their clinical practice as ‘mostly’ or ‘very’ confident post workshop compared to 31 per cent pre workshop.

Formulation in teams

Figures 4 and 5 demonstrate the reported changes in knowledge and confidence about the use of formulation following the training session on ‘Formulation in Teams’:

Figure 4: 83 per cent said that their knowledge of formulation was ‘good’ or ‘very good’ post workshop compared to 29 per cent pre workshop.

Figure 5: 64 per cent said that the extent to which they would be able to make use of formulation was ‘good’ or ‘very good’ post workshop compared to 27 per cent pre workshop.

These results are slightly lower than after the initial training on formulation and might suggest that staff were understandably a little less confident about using complex formulation in teams than they were about being able to make use of formulation more generally.

At the end of the second training session 69 per cent of staff said that they were at least reasonably confident about facilitating a team formulation meeting in their team and 13 per cent were extremely confident.
Overall, these results were positive and in line with what might be expected from good training. We managed to target the staff we hoped for and there was a good turn out from most of the professional groups. The psychiatry group was least well represented – this may have been due to time pressures but also could be because of uncertainty as to their role in MDT formulation. This was unfortunate as psychiatry input into a team formulation approach is essential and their contributions were missed. However, we did have support from a few key psychiatrists, one of whom went on to facilitate one of the newly formed formulation meetings. We continue to work on this and to think about how the new service structures can better support a multidisciplinary approach.

Current practice and next steps
Staff were also asked prior to the second training about their current use of formulation, and at the end of both trainings about what would help them to increase their use of formulation.

Use of formulation prior to the second training session
Prior to the second training 62 per cent of respondents said that they were regularly using formulation. Following the training 93 per cent said that they thought that they would now be able to use it regularly. Staff were asked how many service users in their team had been offered a formulation. A mere 2 per cent said that none had, 62 per cent said that very few or some service users had, 21 per cent said most or all had, and 15 per cent said they didn’t know.

Prior to the second training 40 per cent said that there was currently a team formulation meeting in their service. Some 37 per cent of those who said there was a meeting said they had never attended the formulation meeting, whereas 25 per cent said they attended regularly.

How to increase confidence in using formulation
The themes that emerged in response to this question after both sessions were:
1. More practice was needed – regular practice in MDT, more experience of being involved with formulation and putting it into practice.
2. More training – requests for regular top-ups or refresher training in six months.
3. Supervision.

Table 2 shows responses to the question: ‘What will help increase confidence in using formulation?’
It was valuable to have a clear message about what would need to happen in order for staff to be able to put the training to best use and meet the aim of developing formulations with all their clients. Time was a clear issue (formulation meetings are not counted as direct contact and therefore are not so readily valued). The need for a regular team formulation meeting, supervision and management support were all highlighted. The importance of continuing to engage our managers in this project was recognised, and in particular to ensure local team leader support to enable ongoing integration of the ideas into practice. It was with this in mind that the locality-based MDT practice development groups, which included team leaders, had been set up.

Following the initial training in March and June, the local practice development groups were assigned two tasks: setting up regular local groups to support formulation practice, and setting up team formulation meetings. It was also agreed that we would meet as a group across the Trust every six months to share best practice and ideas for ongoing integration, and to maintain focus and motivation in the face of so many other demands on staff time. Since then, we have met on three occasions for half-day catch up sessions, which have included feedback on the training evaluation, sharing of ideas, and a presentation from Sarah Dexter-Smith on her later life formulation project in Tees, Esk & Wear (Dexter-Smith, this issue).

The following actions and decisions evolved from the training, the follow up meetings and the practice development groups:
1. We are now able to record a direct contact for formulation meetings and discussions on our electronic system. This validates formulation as a form of clinical activity and will in time create the possibility of auditing the amount of time spent on formulation.
2. In order to make formulations easily identifiable in the electronic notes, it was agreed that they would be pasted into the uploaded documents section under the heading of ‘Formulation’. A space for ‘Formulation’ was added to the new assessment paperwork to ensure that it was always documented.
3. Team formulation meetings were set up in each new assessment and treatment service. These usually happen weekly, or every two weeks, and are largely facilitated by psychologists.
4. The project and the concept of formulation were presented and discussed at service user forums and were well received. Having started these conversations, we want to follow it up by, for example, developing a service user/carer leaflet on formulation to give our users more information on what it is, what to expect, and how they can be more involved.

However, the more we meet and discuss the issues around formulation, the more we realise we still have to do.

Some of the outstanding issues and concerns are as follows:
1. How to involve service users/carers more in this work.
2. How and when to share formulations with service users.
3. Clarity of approach – to use one model or several.
4. How to work more closely with our psychiatrist colleagues on formulation.
5. How to ensure good quality formulation continues to be a part of routine practice. Finding time for developing and writing up a formulation continues to be a challenge. We want to ensure that formulations are good enough working hypotheses to be developed throughout a service user’s journey through services, whilst minimising the burden on staff.

**Evaluation**
As part of Phase 3 of the project we asked a trainee psychologist to review the impact of the training across the assessment and treatment services one year on to see whether the immediate benefits of training had been realised and where there were the gaps (see Chiffey et al.).

**Summary and reflection**
What started out as a six month project soon extended to two years and onwards as we
realised that training in itself is never enough to bring about real change in practice. The main focus of the work, outside the logistics of mass training of an entire MDT workforce, was trying to make sure that practice changed in the localities. Identifying locality leads and developing practice development groups that included team leaders was key to this process. However, trying to engage staff who were already quite overwhelmed in some services with so much change – of base, of team structures, personnel and of ways of working – was no mean feat. As project lead, Philippa Casarees put a lot of energy into encouraging and supporting staff to see the benefit and value of this way of working in spite of the pressures, so that the long term-aim of improving the quality of care to our service users was always at the heart of the work. The project relied on the good will of clinical leads and team leaders across the Trust to continue to support and encourage the work in their own localities. Currently, although we do have good management support for this work, the formulation meetings are largely still facilitated by psychologists and the locality champions are largely psychologists. Some of this is due to time constraints and the role definition of other professionals making it harder for them to justify the time to promote and lead this way of working. Our experience is consistent with other services, where it has been found that while formulation has great appeal to MDTs (Hollingworth & Johnstone, 2014) embedding it within services is a complex and demanding task that takes time (Dexter-Smith, 2010; Dexter-Smith, this issue).

In conclusion, it is clear that the training itself was well received, relevant and valuable and helped staff to feel more knowledgeable about formulation and more confident about using it. It also functioned as a team building exercise for these newly developed services. However, clearly there is still a long way to go to reach our goal of every service user having a collaboratively-developed formulation that informs their care plan and is easily identified in the notes. We do believe we are at least heading in the right direction.

My experience of the formulation space has been very good and it’s really exciting for me to see the approach spreading gradually into our culture and general practice. I think the space itself gives us an excellent framework for establishing (or re-establishing) the client’s story and background, which allows us to develop a much more conceivable account of what might be happening for them on a deeper psychological level. I’ve found it to be a very holistic and person-centred process. Its non-stigmatising and I like that it is fluid and open to change/adjustment. I like that it helps me, as a member of staff, to feel like I know why things are happening as they are. This not only helps me to feel a much deeper sense of empathy, it gives me/the team a much more credible basis for establishing the best form of treatment or intervention for that person. In a nutshell, I think it raises the standard of care we are able to offer to people, and to my mind that is what services should have been doing all along! (Alex, Support Worker)

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References
The emotion focused formulation approach: Bridging individual and team formulation

Isabel Clarke

The emotion focused formulation approach has been developed and evaluated in acute mental health services since 2004, but is being applied more broadly. Its application both as an individual and a team formulation is explored, along with its cognitive science basis.

The emotion focused formulation approach can be seen in two ways: either as a simplification of standard cognitive behavioural therapy and cognitive analytic therapy formulations, or as radically different in attempting to meet the individual from the inside: that is, from a place of felt sense. It was developed as a collaboratively-arrived-at individual formulation, but is well suited to use as a team formulation, either in addition to or instead of an individual formulation. Evaluation of the approach to date has focused on individual application.

History of the approach
The publication of the interacting cognitive subsystems model of cognitive architecture (Teasdale & Barnard, 1993) underlined the importance of working at the ‘implicational’ felt sense level in order to facilitate real change for people with more severe mental health problems, leading to the first publication advocating the application of interacting cognitive subsystems to such presentations using this type of formulation (Clarke, 1999). This development chimed in with the clinical impression that those individuals seen in clinic (inner city outpatient psychological therapies department at that time) were driven to do or not do whatever was causing concern to themselves or others (self harm, self neglect, etc.) by an intolerable internal state that they understandably sought to escape.

The arrival of third wave, mindfulness-based developments in cognitive behavioural therapy at the same time (e.g. Kabat Zinn, 1994; Segal et al., 2002; Hayes et al., 1999; Linehan, 1993) made possible the further development of the therapeutic approach, bringing in the use of mindfulness to break self-defeating behavioural cycles, and a dialectical behaviour therapy type, skills-based approach, to simplify and distribute support for alternative coping. I first developed the approach in the 1990s for use with individuals in order to manage an overloaded outpatient service without an accumulating waiting list.

Between 2004 and 2010, I was able to develop and adapt the approach to providing a psychologically-informed service to a well-resourced inpatient and community acute setting. This work was evaluated and published (Clarke & Wilson, 2008). Individual formulation continued to sit at the heart of the approach, but working with the team, and using both the formulation and the understanding of mental health difficulties that underpinned it, was a key aspect.

Since then, the approach has been introduced across the acute services of the Southern Health NHS Trust and the evaluation is being written up (Araci & Clarke, 2014; Araci et al., 2014a; Araci et al., 2014b). The results suggest improvement on, for instance, the Mental Health Confidence Scale for those undergoing the programme, and the acceptability of the approach in a busy acute service. This represents a more comprehensive application than described in the pilot study, with training delivered to over 200 staff of all professions, including managers and consultant psychiatrists, and around 64 service users attending groups, receiving formulation, etc. each month, over the four areas. Significantly for the survival of psychology services in this age of austerity, the Trust’s commitment to
the model has led to the maintenance of a historically good level of psychology provision in acute services, and a recognition of the need for senior posts where psychologists are taking a leading role in the service.

The model is also being applied in primary care IAPT services to meet the needs of an identified population who do more poorly with the NICE adherent treatment. Introducing individually tailored, as opposed to diagnosis-specific formulation into IAPT, represents a new departure.

**Rationale: Current response and past trauma**

The understanding of mental health difficulties underpinning emotion focused formulation is simple. The behaviours underlying all mental health diagnoses are understandable attempts to manage intolerable internal states (a ‘what it feels like to be me now’ that is simply too challenging to face) (Clarke, 2009). Self-harm and withdrawal are common reactions. Ruminative worry keeps anxiety on the boil; changing the agenda. ‘If I wash my hands enough, if I am thin enough…’ appear to offer solutions, and for those high on the schizotypy spectrum, the option of escape to another dimension (psychosis) is available. As immediate strategies to cope with adversity, most of these are familiar to all of us as short-term responses, including one favoured in our society: use of alcohol.

Teams can understand this when it is brought home to them through a training exercise. Where straight empathy flounders is in the need to factor in the effect of past trauma and the compound effect of repeated trauma on people’s response to current adversity and to their experience of self. Interacting cognitive subsystems provides a powerful, cognitive-science-based explanation for the way that trauma memory operates outside of time and disrupts an individual’s ability to form a coherent and good enough experience of self, leading to that desperate need to escape. Brewin and others’ research into trauma memory (Brewin et al., 1996) tells the same story.

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**Figure 1: A typical formulation**

![Diagram of a typical formulation](image)
The emotion focused formulation approach encapsulates this extremely simply (see Figure 1). The intolerable internal state is identified as the source of whatever problem behaviour, experiences (in the case of psychosis), etc. have brought the individual to the service. This is drawn as a jagged shape in the centre of the diagram. The immediate trigger is identified, linked to past threat that it has ‘woken up’, and the way they combine to produce the intolerable feeling at the heart of the diagram is normalised. The past and triggering events are encased in a box. These are the important context for the distress, but are unlikely to be amenable to short-term change. The maintaining cycles are then drawn out collaboratively as precise behavioural analyses, arising out of the spiky centre, leading to short-term relief (the reinforcer), but ultimately feeding back into the spike, and so continually maintaining and intensifying the intolerable state. Where this is constructed collaboratively with an individual, it is vital that they can own both the reinforcer and the ultimately self-defeating aspect of the coping strategy.

Choice of language is crucial to this formulation. It needs to be immediate, everyday and ideally use the service users’ own words. Professional jargon phrases like ‘low self-esteem’, ‘maladaptive coping’, and so on need to be translated into respectfully phrased behavioural alternatives that bring home inescapably what is actually going on, or has gone on. Sensitivity to what the individual is ready to face at this point in time is needed, particularly in relation to the feelings named at the centre and the brief encapsulation of the past. For some people, past abuse is readily acknowledged, but for others, a phrase like ‘bad things in the past’ is as much as they actually want to see down on paper, but this is sufficient to make the point that there are good reasons why the current situation is so unmanageable. The driving feeling at the heart of the diagram can be described with as much vagueness or precision as is right for that person – from a question mark to a number of words and phrases, including cognitions such as a ‘I am a failure’, if spontaneously expressed by the individual.

The completed diagram is usually received as an accurate (if not always welcome) depiction of their predicament, and as it illustrates clearly how stuck they remain while using these strategies, provides a good starting point to look at where to break the cycles. This is the hopeful part of the message. The challenging part is easier to hear because of the powerful validation provided by placing the spike in the centre of the diagram and normalising the effect of the past.

**Distributed working**

One effect of this formulation is to break down the problem in a way that suggests quite straightforward skills-based behavioural changes, which can be taught and supported by someone other than the formulating therapist. The therapist undertaking the formulation needs to have adequate background and supervision as, though simple, the approach is quite subtle and could be very counter-productive if done badly.

In inpatient, community treatment and other team settings this is an opportunity to involve the team in the psychological approach. Ideally, they need some training in the model, so that they can see mental health problems in non-diagnostic terms and can understand the impact of past trauma on current distress as a basis for more accurate empathy. The individual collaborative formulation can be shared with the team, and the interventions identified to break the vicious cycles can then be owned and supported by the whole team.

There are different ways of sharing the formulation. It can be presented to a multidisciplinary team meeting for discussion on how to embed in planning. Working in the inpatient unit, it often made sense to involve the key nurse or other member of the ward team in the formulation meeting. Without prompting, they were usually able to identify areas where they could support the next steps. Similarly, in preparation for discharge, it was important to find natural allies for the practice and development of new skills by inviting family, partner, carer, etc. to a meeting where the service...
user could explain, using the diagram (which had often already been shared to help important others to understand), what skills they were trying to use and what they would find helpful in terms of support – and what would be less helpful. The therapist then lists these in a written document for all to take away.

In the acute setting, programmes were provided by the service to be accessed equally by the in- and outpatient arms of acute mental health, to support new skills that address the commonest vicious circles. Mindfulness is an obvious first step for revising habitual patterns, and is accessible in safe and simple form early on in the admission through mindfulness groups on the ward. The interacting cognitive subsystems/dialectical behaviour therapy model, placing the disjunction between emotional and rational processing at the heart of mental health difficulties, points to the centrality of arousal management, both down (stress control) and up (activity scheduling, etc.). This is highly suitable for delegation via manuals, support etc. As a dysfunctional self/self relationship is equally central to mental health presentations, we added a ‘Compassionate Friend’ group to address this. A programme introducing non-stigmatising ways of understanding voices and other anomalous experiences, that helps to preserve self-esteem while teaching and promoting the use of self-management skills (Wilson et al., 2009; Clarke, 2010) was part of the original pilot. A dialectical behaviour therapy-based, short (8–12 session) emotional coping skills group lies at the heart of the programme.

These groups do not only supply the skills for service users to break the self-defeating patterns identified in the formulation. They are a crucial means to introduce the wider staff team to psychological working. Given management co-operation and adequate staffing, staff can progress through observation and supervised practice to become facilitators, or use their familiarity with the programmes to coach use of new skills as needed. Ideally, psychological interventions become ‘the treatment’ with equal status with medication and service users are consistently encouraged to use their skills and to attend groups.

**Team formulation**

It can be seen that when this system is working well it promotes psychological thinking about problems and solutions throughout the whole team. In acute services, the formulation, originally derived from an individual, collaborative process, becomes a more public document, shared with the rest of the team, informing care planning, and frequently shared with the service users’ family/carers. The language is chosen with the sensitivity of the service user in mind, balanced with the power of naming what has happened and its impact on the current situation.

The same model of formulation can be and frequently is used as a purely team formulation in the absence of an individual version. This might be where the team needs to understand someone who has not engaged sufficiently for an individual formulation to be practicable; where there has not been adequate therapy resource, or indeed in a service where there is insufficient capacity for individual formulation. It has particular strengths used as a team formulation. For one, empathy is inescapable. Behaviour is sourced to the internal reality for that person; the impact of trauma is emphasised, so enabling accurate as opposed to ‘false’ empathy. By false empathy, I mean the sort of process that concludes that behaviour is manipulative in intent. Behaviour such as repeated ligaturing has the effect of annoying staff and making discharge difficult. Understanding the desperation behind the behaviour (or its original, where it has become habitual) and the source of that desperation (for instance, in past trauma) is crucial so that the staff group does not dismiss it. This type of re-appraisal lies at the heart of developing more compassionate services.

The formulation is also a powerful way of helping teams to identify the behavioural cycles maintaining the problem, and so the most efficient targets for intervention. It dis-
encourages further exploration of areas which might distract from the immediate and challenging task of working on change, at the same time as emphasising their importance for understanding the present. This is also useful for assessing motivation on the part of both the service user and the team to work on change. Where the way ahead is clearly stated, it is easier to discern whether the parties are ready to accept this challenge. This can help clarify whether the continuing involvement of the service is productive, thus promoting more efficient use of resources.

Similarly, issues of positive risk taking become much clearer when the formulation can show whether the service has become part of the problem. The individual’s habitual solution to a situation they feel unable to address; for example, maintaining service involvement by attempted suicide, is highlighted. Revealing this makes possible a balanced risk assessment. The risks of, say, completed suicide, are acknowledged, but so are the risks of loss of independence, self-efficacy and coping capacity if the service remains stuck in a self-defeating the rescuer role.

**Conclusion**

Of course, other ways of formulating will cover all these areas. The strength of emotion focused formulation lies in the immediacy of placing felt sense at the heart, thus inviting powerful empathy, and the inescapability of the message conveyed by clear and simple behavioural cycles, using everyday, jargon-free language. It is hoped that this article has given some idea of the operation and potential of the emotion focused formulation, both at an individual and at a team formulation level. More information, including manuals for group programmes, is available on the author’s website (www.isabelclarke.org).

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Team formulation within a learning disabilities setting

Barry Ingham

In recent years team formulation has played an increasing role within services for people with learning disabilities. The following paper outlines the initial development of an evidence base in this area and how this may be built upon further.

There has been a developing interest in the application of case formulation within learning disability settings, across different therapeutic approaches and presentations (e.g. Kirkland, 2005; Drury & Alim, 2014). One of the long established key considerations within learning disabilities services is the high levels of formal and informal support that exists to meet needs associated with a higher degree of vulnerability and less well-developed self-regulation skills (Department of Health, 2001). A significant number of people with learning disabilities experience additional psychological problems (e.g. severe mental health problems; significant challenging behaviour). Where this occurs, people with learning disabilities are increasingly likely to rely on a system of support (including family, direct care staff or other professionals) that may encompass a variety of views on the nature of the problems that they are experiencing. As such, there is a necessity to have effective and efficient ways of collaboratively developing case formulations with the wider system around them. This paper provides an overview of how this has proceeded over recent years and potential next steps.

Team formulation structure and applications
Team formulation within learning disability services has developed to take different approaches across settings and structures. A psychobiosocial model is frequently used as the basis for formulation development (Ingham & Clarke, 2009). Within this, a Five Ps framework has often been applied to help organise and integrate information (Ingham et al., 2008; Ingham, 2011). The Five Ps framework is a broad structure which allows organisation and integration of information under a number of headings (Presenting; Predisposing; Precipitating; Perpetuating; Protective; see Ingham et al., 2008 for definitions associated with these headings). The main advantage of both the biopsychosocial model and Five Ps framework is that they are broad enough to encompass a range of presentations and disciplines. This facilitates inclusion of all multidisciplinary team members. It is also sufficiently accessible, with brief training, for unqualified direct care staff members to both develop and understand formulations. As such, this model/approach has been applicable for team formulation at different levels and settings.

The model has been used across different settings to support multidisciplinary working (Ingham et al., 2011), help inform treatment (Ingham, 2012), improve outcomes (Ingham, 2011) and facilitate service user contribution to care planning (Rowe & Nevin, 2015). This paper will outline how the model has initially been applied across these different settings.

Working with direct care staff
The author has developed a case formulation workshop protocol for working with direct care staff teams (Ingham, 2011). This uses the biopsychosocial model and Five Ps framework to develop a formulation collaboratively for the person with learning disabilities that the staff team supports. Over the last ten years in the
author’s employing organisation, case formulation workshops have been used to support formulation-based working across the service. The workshops have been applied with direct care staff teams in community (Ingham, 2011) and inpatient (Ingham et al., 2008) settings which support people with learning disabilities who display challenging behaviour or experience mental health problems. The workshops were initially led by clinical psychologists; however, as they have become more established this role has also been undertaken by qualified nurses, with supervision and support from psychology. The case formulation workshops include undertaking appropriate assessments in relation to the service user (e.g. a notes review) and developing an understanding of the functioning of the system around the service user (e.g. readiness of that system to support the workshop process). The workshop itself is generally facilitated by two clinicians, usually including a clinical psychologist. It can be beneficial to have another qualified professional from a different discipline present, since this enables facilitation from different perspectives, and potentially, the opportunity to increase involvement from all participants.

The first step in the workshop is to discuss the prepared notes review. This includes collated information about the past experiences of the service user as well as structured information (e.g. through a genogram and timeline). Discussion of the notes review gives an opportunity to check the validity of the information and also start conversations and hypothesis generation between participants. The facilitators are then able to introduce the concept of formulation as a way of helping to organise the information generated through these participant conversations. A set of slides is then used (see Ingham et al., 2008, for details of these materials) to provide basic training in formulation and the Five Ps framework. Following introduction of each of the Five Ps sections, participants are encouraged to discuss the service user they are supporting in the context of that section (e.g. for predisposing factors, participants are asked to consider the internal and external past events which are likely to have contributed to the person’s vulnerability to experiencing difficulties at this time). The facilitators organise this information and record it throughout (e.g. using flip chart paper). Therapeutic techniques such as cognitive-behavioural and systemic strategies are employed to facilitate discussion; for example, Socratic questioning is used to elicit different perspectives and guide discovery; circular questioning is used to better understand interactions and relationships between staff and service user. The facilitator endeavours to integrate the information so that there are clear links that offer a coherent explanation of the difficulties. In doing this, the facilitator also needs to ensure that the integration and explanations are sufficiently accessible to direct care staff without specific training in psychological models. As this process occurs there are opportunities for the facilitator to observe staff values, attitudes and knowledge in relation to the service user and their needs. Gaps in knowledge and negative or unhelpful attitudes may be addressed within the context of the workshop. However, this may also highlight the need for wider systemic interventions for the staff team beyond the workshops (e.g. specific training programmes; improved leadership).

The process is repeated until all Five Ps sections are completed. At this point, the facilitator integrates the information from each of the Five Ps so that a coherent formulation is offered with key dimensions and hypotheses that could potentially be tested with appropriate interventions. This leads onto the final section of recommendations. These are explicitly informed by the formulation, and form the basis of a treatment/care plan with short-, medium- and long-term goals (again driven by the formulation). Ideally, both treatment plan and formulation are reviewed within statutory structures (e.g. Care Plan Approach, Mental Health Act reviews) and informal processes (e.g. multidisciplinary meetings; supervision). Where required, this can also include follow up workshops to revise the formulation in the context of the outcomes of the interventions.

**Working with multidisciplinary staff teams**

The formulation process described above has also been used in multidisciplinary teams within learning disability services across the author’s employing organisation to encourage formulation-based multidisciplinary working (Ingham...
Team formulation within a learning disabilities setting

& Clarke, 2009; Ingham et al., 2011). This was initiated and led by psychologists (including the author), and as the process became more established, non-psychologists (e.g. nurses) have increasingly taken on facilitation of formulations within multidisciplinary teams. Consistent principles (i.e. collaborative development of a formulation using cognitive-behavioural approaches) have been applied across settings and with different staff groups with appropriate adaptations. This has raised the question of what impact the approach may have and the mechanisms of change that may be acting here.

The author undertook a survey of multidisciplinary staff who participated in team formulation workshops within an acute learning disabilities inpatient service (Ingham et al., 2011). This highlighted specific areas where the formulation process was perceived to be helpful in supporting collaborative working towards shared goals. It also showed areas where there was less agreement about the support it offered (e.g. at times staff reported that, whilst the process was useful and supported multidisciplinary working, it did not always help them to understand the service user more than they already did). The latter example highlights one of the challenges of implementing team formulation as team members may feel that they already know and understand enough about a particular service user, so they do not readily see the value of the process. It can be helpful to remind staff of the usefulness of ‘sharpening their own saw’ in relation to the service user as well as using team formulation to develop understanding within the team as a whole, or ensure that the team have clearly defined formulation-driven goals for the service user.

The author and colleagues have carried out additional small scale projects that explored the change mechanisms occurring within team formulation (Hymers & Ingham, 2010) and the reach within the service of team formulation (Oliver et al., 2010). Hymers & Ingham conducted semi-structured interviews with multidisciplinary staff members who had participated in formulation workshops and found three key areas of change: altering staff thoughts in relation to the person; gaining information about the person; and focusing treatment goals. The interviews suggested that the workshops were able to support these changes through facilitating a collaborative approach and providing a reflective space for multidisciplinary staff members to develop their understanding of the service user. However, it was also identified that these changes were less likely to happen if communication within the team was poor, or if appropriate team members were not in attendance at the workshops. Despite this, the impact and understanding of team formulations following a service-wide introduction of team formulation may be limited in some respects. Oliver et al. (2010), using semi-structured interviews based on Kirkpatrick’s four levels of training evaluation (Kirkpatrick, 2007), found that staff members valued formulation (e.g. they felt it improved care planning) and used formulations innovatively (e.g. to teach new staff about a service user’s needs), but were less clear on how formulations might improve the wellbeing of a service user. Also, not everybody in the service was aware of the formulation process and/or how to readily access these formulations, which suggests that embedding team formulation within a service requires significant work beyond workshops.

Outcomes associated with team formulation in learning disabilities settings

Establishing the effectiveness of team formulation poses a significant challenge due to the complexity and number of variables involved. This is particularly the case within learning disabilities services as there tends to be a significant involvement from multidisciplinary team members across different agencies, often with extensive direct care staff support. For example, a person with learning disabilities experiencing severe mental health problems or displaying significant challenging behaviour is likely to have a large number of people involved in their care, with a number of potentially competing treatment approaches. This presents significant challenges in evidencing a link between formulation and benefit for service users. Nonetheless, there have been initial attempts to explore effectiveness in this area.

A case study by the author (Ingham, 2011) indicated a link between introduction of case formulation workshops and a reduction in observed display of challenging behaviour by
an adult with severe learning disabilities supported by a direct care staff team in a group home setting. While this suggested that this approach may be effective, it also highlighted the problems of understanding the mechanisms involved between workshop delivery and positive impact for the client. For example, it was unclear what changes took place in staff members participating in the workshops. Furthermore, it is unknown how staff behaviour towards the service user changed or how the service user’s care plan was adapted as a result of the formulation workshops. Further exploration of these mechanisms is required to understand their potential influence.

In addition, an earlier study demonstrated the improvements in direct care staff ability to critically appraise a formulation following training in a team formulation format (Ingham et al., 2008). However, it did not explore what input was required to translate this change into practice, or how this process may change staff views about the people they support. A self-report questionnaire which records participant changes in understanding in relation to the person they support, with particular reference to knowledge, empathy and confidence, is under development (Ingham, 2013).

**Involving the service user**

The approaches described above tend to occur without the service user present. This may be important in order to support coordination of treatment planning and/or allow a space to share understanding of distressing information about a service user. However, there is also a potential threat to the validity of a formulation and a lack of inclusion and collaboration with the service user in the process. In response to this, Rowe and Nevin (2015) have developed an approach that facilitates input from the service user into team formulation development. They demonstrated that an individualised approach can be used to incorporate a service user’s perspective into formulation workshops. The approach involves first assessing the service user’s needs in terms of communication, preferences and ability to make choices/decisions. The outcomes of this assessment are then used to inform how best to support the service user in expressing their strengths as well as areas of their life they were struggling with. The information resulting from this was then fed into a formulation workshop and incorporated into the formulation product. Similarly, an approach has been suggested that links team formulation with individual therapy and management of mental health problems (Ingham, 2012). This involves sharing the outcome of team formulation with a service user, who was then able to adapt the formulation within the context of individual therapy. This improved not only the validity of the formulation but also the service user’s ownership.

**Next steps**

The evidence base for team formulation within a learning disabilities settings is limited. The developments described in this paper represent initial steps in establishing this base. Future studies could seek to establish the feasibility of a controlled trial of team formulation within a learning disabilities setting, including developing the protocol for delivering team formulation, identifying appropriate outcome measures and demonstrating the change mechanisms that lead to improved outcomes for service users. Within this, a key challenge will be to explore how best to transfer team formulation products into practice (e.g. through combining with other staff based interventions such as supervision or coaching). A research network has been established to support these further developments and it is hoped this will help to consolidate team formulations within learning disabilities healthcare settings.

**Conclusion**

Team formulation within a learning disabilities setting has increased in popularity over recent years. The approaches used within team formulation and their evidence base have developed alongside this. However, this remains an under-researched area which requires more focused evaluation in order to demonstrate its usefulness.

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References

The British Psychological Society
Division of Clinical Psychology
Faculty for Sexual Health & HIV

Update on the impact and consequences of HIV neurocognitive impairment: Recent research findings and clinical implications
BPS London Office, 30 Tabernacle Street, London EC2A 4UE
Monday 30 November 2015, 9.00am–5.00pm

HIV infection can affect cognitive functioning in children and adults. This event will present up-to-date research findings on the prevalence and impact of HIV infection across the age range. We will also explore the ways in which cognitive rehabilitation can be delivered with a specific emphasis on the rehabilitation of memory functioning.

If you have any enquiries, please e-mail bps@kc-jones.co.uk

To book, go to: www.bps.org.uk/hivsh2015
Team formulation developments in adult mental health services in South Wales

Lucy Johnstone, Caroline Durrant, Lucie James, Heledd Lewis, Elanor Maybury, Shelley McCann, Julian Pitt, Clare Sandford & Jenny Nam

In this article, we provide an overview of developments in team formulation in Cwm Taf University Health Board, South Wales, over the last four years. We summarise some of the challenges and benefits and outline our aspirations for future developments.

Cwm TAF is the most economically deprived Health Board in Wales, with associated high levels of reported trauma, and 13 per cent of its population in contact with mental health services (Cwm Taf Health Board, 2012). The service for adults of working age comprises four locality community mental health teams, each based in a different valley (Merthyr Tydfil, Cynon, Rhondda and Taf Ely). The area is also served by two ‘outreach and recovery’ teams – one in the North of the area and one in the South – and a rehabilitation service which has two wards and purpose-built premises in Treorchy. Three adult mental health wards (one admission and two treatment) and an intensive care unit are situated at one end of the catchment area. There is a total establishment of 11 psychologists, who offer the equivalent of 9.0 WTE input to cover all adult community and inpatient services. Psychology is highly valued and well-integrated into the teams, but inevitably demand outstrips supply.

One-off formulation-based consultation had been offered for some years, but was not a routine part of teamworking. When Lucy Johnstone took up post in January 2011, she offered a half-day training workshop to one of the community mental health teams, which led to setting up regular formulation meetings there. As a result, she was invited to deliver the training in other teams, and with the support of psychology colleagues the approach has spread organically throughout the service. She also offered a one-day training in facilitating formulation meetings, which was attended by most of the adult mental health psychologists. This is likely to have resulted in some consistency of approach, although individual psychologists have a preference for particular models.

The common principles are that, in accordance with DCP guidelines (2011), we see formulation as an alternative to, not an addition to, psychiatric diagnosis, and we advocate a trauma-informed approach which acknowledges the significant causal impact on mental health of adversities of all kinds (Kessler et al., 2010). Within this, we aim to work collaboratively and constructively with all disciplines and models, offering formulation as a useful psychobiosocial perspective.

We see team formulation as a form of supervision or consultation, in which a central place is given to understanding and processing the feelings of the staff who work with a highly complex group. The main client in team formulation is, in a sense, the team, and for this reason not all aspects of the written version (e.g. countertransference feelings) are shared with the service user. However, careful consideration is always given to the most appropriate way of including their perspective and feeding back
our thoughts. Often, this takes the form of a conversation with the service user and perhaps family members before and/or after the meeting, while in other cases the team might write a letter to the service user sharing our thoughts and asking for their views. Sometimes a formulation has already been developed with the service user in individual work, and this provides the starting point for the team version. Our aim is for individual and team formulating and meaning-making to feed into and inform each other.

While the teams vary in the frequency of the meetings, there is in general a good level of appreciation of and commitment to the approach. It has been endorsed by senior management, and all disciplines, from support workers to consultant psychiatrists, are regular attendees. The term ‘formulation’ has become a familiar part of the culture.

Below, psychologists offer a brief reflection on the use of team formulation in their specific areas.

**Community mental health teams – Lucy Johnstone, Hazel Mills, Shelley McCann, Caroline Durrant, Elanor Maybury, Jenny Nam**

Formulation meetings are most thoroughly embedded in the team that first adopted them. After a cautious start, interest and confidence was generated by holding a number of one-off meetings about particularly complex clients. Weekly or fortnightly meetings now take place, with a typical attendance of 5–12 people, including representatives from outside agencies, as appropriate. Staff put forward names of service users they wish to discuss and the key worker supplies a background summary. The psychologist facilitates the meeting and writes up the formulation and intervention plan up afterwards, circulating it for comments. There are regular reviews of longer-term service users in which we re-visit and update the original formulation. Initially, the meetings were mainly used for the more complex and long-standing service users, but recently we have also begun to focus on people at earlier stages in their contact with the team. The process largely drives itself and formulation slots are typically booked up several weeks in advance. Support from the consultant psychiatrist and the team manager has been a crucial part of the process, and formulation discussions are characterised by a high degree of reflectiveness and trauma awareness.

Other community mental health teams have faced more challenges in implementation, such as lack of cover for psychologists’ maternity leave or staff reluctance to put names forward. All the community mental health teams are overworked, and it has sometimes been hard to persuade staff that one hour a week or fortnight could help save time in the long run. In one team the meetings stopped for several months because of workload demands. They have now resumed after careful planning to ensure they are frequent enough to maintain momentum while not requiring an unrealistic time commitment. More emphasis has also been put on team members contributing to the write-up, specifically the sections on life history and involvement with services. This has reduced the burden on the facilitator, while increasing the sense of team ownership.

Some staff initially expressed concern about being judged on their work, but in practice they feel they have derived a great deal of support from the process, not only from the facilitator but also from other team members who may or may not have had input with that specific client. An ongoing challenge is the shift in culture from professionals’ meetings solely aimed at ‘solving a problem’ to the more reflective nature of formulation meetings. Some staff feel vulnerable discussing their feelings whilst others may believe their feelings should be irrelevant (or even non-existent). This has changed with time as staff accept that it is OK to have difficult feelings and share them in this more public forum. Staff have become more confident in participating and team formulation has become a routine and valued part of the culture.

**Inpatient rehabilitation and recovery service – Clare Sandford**

This is a relatively new service, with dedicated psychology provision, thus providing an exciting opportunity to establish team formulation from the outset. The term ‘formulation’ was
already familiar and there was enthusiasm for incorporating this approach. Training for all the rehabilitation staff (provided by Lucy Johnstone) was extremely well received. A multidisciplinary working party, led by Clare Sandford, then met to share ideas and promote ownership of the approach by the whole team, along with overcoming (as far as possible) the practical barriers to implementing it within a large 24-hour service.

Team formulation meetings have now been well established for over two years and run on a weekly basis across the two units, and sometimes more frequently in response to need. The psychologist facilitates all meetings, which typically include representatives from the inpatient nursing staff (ward/deputy ward manager, named nurse and at least one key support worker), medical staff, occupational therapy, and psychology, in addition to community staff where possible (e.g. care co-ordinator, social worker). The meetings are booked and organised by the named nurse, and the psychologist writes up the formulation and intervention plan, and circulates it for comments.

Formulation meetings tend to focus on one of four key areas – Engagement, Risk, Move-on and ‘Stuck’ (based on Whomsley, 2010). Engagement meetings take place for all service users, in order to consider their needs and strengths, and develop a shared understanding of how previous experiences may have contributed to current difficulties. Move-on formulations are used for people leaving the rehabilitation service, and include members of the new teams. These meetings give staff the opportunity to review progress, reflect on their own practice, and pass on their formulation-based understanding to the future workers. Risk formulations use the standardised risk assessment in the Health Board, the Welsh Applied Risk Research Network (WARRN) format. The document is completed by the whole team, which helps professionals to share the responsibility around risk and take a positive approach to managing it. ‘Stuck’ formulation meetings are held when the team feel that they are burnt out, frustrated or not making progress, or when inconsistencies in approach have arisen.

Outreach and recovery
– Julian Pitt, Lucie James

Team formulation meetings have become a core part of team functioning in both the Community Outreach and Recovery teams in Cwm Taf. Formulations follow the same four frameworks as the rehabilitation and recovery service, and serve the same aims and purposes. This is particularly helpful in reducing some of the frustrations often associated with working with hard-to-engage clients.

Both the Outreach and Recovery teams hold weekly formulation slots and all staff are encouraged to attend. Sometimes it has been hard to maintain attendance (as clinical work can take priority) or ensure full multidisciplinary representation. On the positive side, staff have fed back that team formulations help them to think outside the medical model understanding of severe and enduring mental health problems, and in particular to consider the impact of difficult life experiences on the client’s current presentation and pattern of engagement. Overall, these meetings have been embraced by the staff, and have a central role in promoting a whole team approach to working with this complex client group.

Admission and Treatment wards – Heledd Lewis, Shelley McCann

As in other mental health settings, team formulation on an adult inpatient unit promotes a psychological understanding of mental health difficulties as an alternative to the medical model perspective which often dominates in this environment.

Introducing team formulation within inpatient settings requires careful planning to embed it within a culture of ward rounds, medication rounds, etc. Encouraging this type of reflection within an already overstretched and busy environment can feel like an extra time consuming task. Furthermore, formulations are not always passed between shifts, so information can get lost. Ongoing work is needed to ensure that information is routinely included in paperwork and computerised notes, and continues to guide decision making, even or especially in crises. We are looking at developing a simpler formulation template to facilitate this, as well as offering additional training to staff.
Meetings are often requested when the staff feel stuck with engaging with a client, or are unclear about the reasons for their distress. Other situations are when a service user is not progressing towards discharge, or when their risk becomes difficult to manage on the ward. At these times team formulation has worked well to develop an alternative way forward or risk management plan. Working in the fast paced environment of an acute setting also means that plans can be put into place with immediate effect and the client and family (if appropriate) can receive feedback and input in a timely way that facilitates recovery and reinforces their sense of ownership and responsibility.

Establishing regular team formulation meetings on these inpatient wards has been challenging and required active promotion by the psychologists. However, at its best it has provided an opportunity for all members of the ward team to work alongside community services to develop a coherent narrative about the person’s difficulties and a shared way forward.

**Evaluations**

A before-and-after evaluation of the staff training package showed that attendees’ knowledge about formulation and their confidence about contributing to a formulation meeting had significantly increased, with almost 100 per cent endorsing these items either positively or very positively. Some 73 per cent of attendees rated the training session as ‘very useful’, with nearly all the remainder rating it as ‘useful.’ Informally, we feel that these training sessions played an important role in demystifying the term ‘formulation’ by linking it to the work that staff already do, demonstrating its potential uses, introducing a trauma-informed perspective, and creating interest and enthusiasm.

An initial evaluation of staff views about participating in the team formulation process was extremely positive, with 100 per cent of the respondents reporting that the meetings had helped to:

- generate new ideas about working with the client;
- develop an intervention plan; and
- improve risk management (Hollingworth & Johnstone, 2014).

Staff also reported other benefits, including feeling more empathic and more hopeful about recovery. We have continued to collect evaluation forms and have received equally positive responses, despite some variation in format, therapeutic model and personal style across different teams and settings. This suggests that something about the team formulation process itself is perceived as very valuable by the staff.

Among the gaps that remain to be filled are:

- How do service users experience the team formulation approach, whether they are involved directly or indirectly?
- What are the most effective facilitation strategies? How have barriers and challenges been overcome?
- Does the approach improve outcomes on measures such as levels of distress, use of medication, number of admissions, and so on?

**Reflections**

All the psychologists report that team formulation places fairly heavy demands on their time and skills. As others have also found (e.g. Shirley, 2010), facilitating meetings is not always an easy process, especially when team dynamics, countertransference reactions and tensions between models are played out in the room. Writing up the formulations is a time-consuming task that we have not generally succeeded in devolving to any other discipline, with the occasional exception of social workers. A considerable amount of prompting and organisation may be needed to ensure that the meetings happen, at least in the initial stages. Perhaps inevitably, the Admission and Treatment inpatient wards have presented the most challenges due to shift patterns and a rapidly changing population.

On the positive side, the approach is widely welcomed by staff, and has met very little resistance. Feedback suggests that it has
given a voice to team members who may not have felt able to speak up, and has encouraged all staff to reflect on the ways in which we may inadvertently be perpetuating people’s difficulties. The bottom-up rather than top-down method of dissemination may have helped in this respect. In keeping with the spirit of formulation itself, we have gone where we have been invited, offering rather than imposing this perspective, and being willing to adapt to the needs of particular teams. Word has spread: training has also been requested by and delivered to local social care teams, while Cardiff and Vale Health Board are adopting the model in their services.

Our aim, in common with others who have pioneered this approach (Kennedy et al., 2003; Summers, 2006; Lake, 2008), is not just to develop more effective interventions for specific service users but to achieve a cultural shift in the way that psychiatric problems are understood. It has been very rewarding to see some notoriously ‘stuck’ service users being enabled to move on – although there are rarely simply solutions. But perhaps more importantly, we have observed a much increased awareness of the causal role of trauma and adversity, along with a reduced tendency to see problems in terms of narrow diagnostic categories. Students and visitors have commented on the sophistication, thoughtfulness and reflectiveness of the formulation discussions.

Team formulation has paved the way for other developments. A successful and well-attended CPD day on ‘Trauma-informed Services’ was held in 2013. This in turn led to another ongoing project, in which a multidisciplinary group of staff has been trained to set up a rolling programme of groups for women survivors of sexual abuse in each of the locality teams (with thanks to trainers from the Exeter SAGE project (www.devonpartnership.nhs.uk.) In addition, the community mental health team psychologists have recently developed and circulated a ‘Stabilisation Pack’ consisting of a series of leaflets on coping with the effects of trauma, in order to develop multidisciplinary team staff confidence in first stage trauma work.

This has been enthusiastically received by all disciplines, and is undergoing service user evaluation. Future aims and challenges are:

- Ensuring that recommendations from the formulation meetings are put into practice.
- Ensuring that formulations occupy a central place in the electronic records and official documentation and do not get lost between teams and services.
- Embedding formulation into the care pathway for all service users.

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Implementing psychological formulations service-wide

Sarah Dexter-Smith

This article outlines our experience of implementing psychological formulation across a whole service. We hope that this will help to start some useful local discussions and would be interested to hear what is happening in other services.

‘It’s been particularly good for developing psychological thinking in the teams, for developing team cohesion, for raising the profile of psychology, and for giving the teams a sense that we are here to help and help rapidly.’ (Clinical Psychologist)

The changes, agreed between clinical and operational leads, started in 2007 on one organic and one functional ward for older people. In conjunction with occupational therapists and nurse leads, we trialled using a cognitive behavioural therapy formulation to underpin the two clinical models of care for these units. We gradually expanded this, and have now trained around 550 staff across 11 community teams, including intensive and care home liaison, and nine wards. Each service uses it differently. In the inpatient services most patients have a formulation soon after admission. Community teams use it more flexibly for fewer patients; some are guided by needs defined by cluster (e.g. all patients in cluster 8), some incorporate it into review processes, others when they feel worried or stuck. Serious levels of risk or team conflict also trigger a formulation. All formulations are entered into the electronic notes system with a ‘formulation’ tag. Psychological formulation is recognised as a specific activity and psychologists have sessions identified in their job plans specifically for formulation meetings. Psychological formulation also forms the basis of other service developments:

- We have a specialist network that provides a senior manager and clinician to help teams that are stuck or conflicted about their care of an individual patient; at its inception, managers insisted that the team had worked through a psychological formulation prior to the request to ensure efficient use of the network.
- Service-wide suicide risk assessment training is structured around the formulation model. We have also developed a version of the formulation model with specific prompts for what might elevate a person’s risk in each section (Craven-Staines & Marshall, this issue).
- The challenging behaviour ‘clip’ to our dementia pathway is hinged on an initial formulation.

Stating our progress in black and white makes it seem tidy and easy. It’s been far from that and what follows is some of what we have learnt over the past seven years. Over this period three trusts have joined and we recruited a significant number of new psychologists. Each change has brought its own challenges.

Making the case:
Context and stakeholders
Our context has been important and it important to be honest with yourself about the system you work in. We are fortunate to work in a specialty where we are supported by man-

1Throughout this paper I use the word patient. There is no word that I am entirely comfortable with and this is the terminology that the people I work with consistently say that they prefer.
agers: they are always challenging, they insist on clarity, they are focused on what makes a difference to patients and they are willing to take a reasoned chance, evaluate it and then decide. So we knew we would have to be rigorous and demonstrate our worth, but that innovation was encouraged. We also knew what the organisation needed: more personal needs assessments and evidence-based intervention planning; better understanding of risk; less repetition of work; a strengthened nursing voice. Formulation can help with all that and more, but each organisation will have a specific profile of need: look at your Care Quality Commission reports; themes from serious incident review; financial risks; and patient, carer and staff feedback. This will help articulate the value of formulation in a way that the people you work with will be able to hear.

It helped that those first two wards were struggling to the extent that a high level management programme had been implemented and psychology was formally identified as being part of leading this change. Sometimes the highest status teams and organisations can be the most resistant to change (Wootton, 2007, p.254). The wards were generally ready to change (they had to) and to deal with barriers. In essence, they had less to lose and were quick to tell the story of successful change, as their motivation to change external perceptions was high. So we had the invitation to do something but not the ‘how’. We knew why we were trying to implement this way of working, but it can be hard to put into words something that is so fundamental to your own way of seeing the world. When we started there was very little psychology resource in mental health services for older people and we needed an effective way of bringing psychological thinking to bear on more people’s relationships with services and care earlier. We also wanted to promote the value of thinking psychologically for the staff and wider organisation, and strengthen the patient’s voice in the service’s narrative, all built on a clear theoretical framework. And it was our responsibility to do this in a way that the system around us could make use of and cope with. Our work was inevitably only one of many changes that staff were attempting to negotiate and this has remained the case ever since.

There will be many reasons why a service is trying to implement formulation-based thinking, but we found that you need to pick a couple and provide a clear and consistent message. The minutiae of what is fascinating to us as psychologists simply clouds the issue for everyone else. We focused on the evidence base for the interventions following formulation (particularly important where positive risk taking was involved) and the containment this provided the team. This contrasted the previous, often ad hoc or heuristically-based choice of intervention. After that, it was really helpful to get the practice of psychological formulation embedded in a clinical pathway (in our case this was initially the dementia pathway); that meant that the guidance to use a formulation came from a ‘third party’ and allowed us to be part of the staff group working to implement it.

John Ballat (2014), talking about compassionate health care, said that a ‘compassionate (and effective and efficient) healthcare is an emergent product of a relational system involving individual engagement and system wide co-operation’. But this needs ‘cultivating’ (ibid.). I would argue that formulations should name the relational systems around an individual patient so that teams notice the common patterns that they set up, get pulled into or sustain. The difference between individual formulation with a patient and formulation with a wider group is articulated in other papers, but for me, one of the central roles of this way of working is the complex task that Ballat described as ‘hold[ing] the clinical and emotional task in mind’ and buffering and managing ‘the process from outside without denial or splitting’.

Governance
Ballat also reminded us that: ‘You need to find a way to bridge the operational and clinical elements of care’. For us, formulation helps with this. But be aware of operational and
human resource implications and help managers address them upfront:

- Will job descriptions or job plans change?
- Are there training implications?
- Will it change the flow of a patient’s care?

The first two wards were a learning curve – the occupational therapy lead, nurse manager and myself found ourselves writing the entire clinical model of care for the units and spelling out the training, supervision, agenda for change bandings, and operational implications for all staff groups. We developed a reflective tool (outlining key elements of process, content, theory and the impact on intervention plans), which we use to reflect on our practice and to assess new practitioners (Craven-Staines & Marshall, this issue). We have had to articulate who can lead a formulation session (banding, profession, training, competence), which has not always been a comfortable process. Our guidance is that for team formulations, staff have to be Agenda for Change Band 6 and above, attend the training, observe five formulations, and be observed competently leading three using the reflective tool.

**Strategic approach**

Introducing change in a complex organisation is tricky, but a wealth of literature has grown up in the last 10 years. When we started, *New Ways of Working for Applied Psychologists* (Onyett, 2007) outlined that a simple problem is one where there is a reliable known approach that delivers almost identical results every time – rare in mental health. A complicated problem requires much higher levels of coordinated knowledge, skills and experience to achieve the required result (i.e. different people with high levels of expertise in many specialised fields that are rigorously coordinated). Formulation helps to coordinate that knowledge in a strong theoretical framework.

The Care Services Improvement Partnership and the Department of Health (2007) advised adopting a whole system approach and keeping rules minimal, simple and flexible. So we adopted one model across most services of a basic cognitive behavioural therapy diagram with interpersonal factors and environmental factors feeding into the ‘hot cross bun’. (See Dexter-Smith, 2010, for more detail). We have recently reviewed the model and developed a new format for team formulation across the whole service; still cognitive behavioural therapy-based, but more accessible. As a profession our skill is in tolerating and exploring uncertainty and multiple narratives. This is an excellent clinical skill and vital in the formulation session itself (both in tolerating it and helping others to do the same), but often a hindrance when trying to achieve a cultural shift. I also think it is unfair on staff tracking patients across teams – the formulation is there to help guide care and recovery. If it changes in format and theoretical stance each time the patient crosses to a new team, it creates the potential for significant error and misunderstanding. Using one model allows you to teach a whole service a language of psychological theory.

If you are using/planning multiple models you need to bear in mind:

- How will you effectively link the operational and clinical structures?
- If in therapy we know that the model is less important than the relationship and that leadership/compassion, etc. are all relationally based, why is the variety of models important in team formulation?
- Does the sometimes unhelpful debate over models devalue the central essence of psychological formulation as a process?

Regardless of the model(s) that you work with there are a number of things to bear in mind. It has to be useful for, and incorporate information from, the whole multidisciplinary team and suit the client group. In mental health services for older people, biological elements are often pronounced and lead to changes in identity, role and functioning. We also needed to include capacity and cognitive issues. But each service has its own profile, and it is important to be clear about how the chosen model matches this so that you are not seen as simply furthering the interests of a few psychologists.

**What to call it?**

I think you have to take the bull by the horns and explicitly name it. We called it psychological formulation right from the start and
defined the psychological theory on which it was based. That also meant we could teach other people that model and demystify it. Calling it something ‘less threatening’ seems appealing in alleviating potential inter-professional tensions in the short-term. But every mental health professionals’ role is to understand and alleviate psychological distress – formulation provides common ground in thinking about models of psychological functioning. I also think that not naming it devalues what we are doing and our skill in being able to facilitate it. If we’re not clear what we are doing, it is difficult to complain when commissioners and managers ask what we bring that’s different.

We also needed the support and confidence to step into situations that everyone was struggling with. It was daunting, but if we hadn’t modelled confidence that the formulation would help the patient, us and the team make sense of what was happening, then it would have been unrealistic to expect staff to make a change. Unfortunately, the point is exactly that you can’t know the outcome before you start and have to hold onto the value of the theory you are working to. Trainees were excellent at suggesting that formulation could help in situations where qualified psychologists (myself included) might have been more reticent. One success that helps the patient and staff feel contained and regain hope will build the narrative of the value of formulation for you. For me, this was a patient who went from having two members of staff at arm’s-length observation due to suicide risk (with incredible levels of staff anxiety) to living in a residential care home. Two trainees suggested a formulation in a meeting I wasn’t at; I was fairly apprehensive about whether the formulation would make any difference. But it made sense of the traps the team were getting into so that they were able to spot it and help each other behave differently. So although the outcome was wonderful, the critical element for the staff was that they understood the difference they had made and were able to share this with the staff in the care home. When other situations with patients seemed overwhelming or hopeless, that staff group would often remind each other of how they had understood this patient.

**Concluding comments**

Feedback from conferences is how overwhelming it seems to look at the end result of ours and other services that have managed to implement this way of working. I would have been overwhelmed too if I’d been given the instruction to ‘train 500 staff and develop a governance structure across all services’. The experience of Sussex Partnership Trust is a credit to Philippa Casares and her colleagues (Casares & Johnstone, this issue), but this is unusual and most people will probably be starting in one or two teams. Start with small steps, but keep an eye on the bigger picture. It’s easy to get overwhelmed by what you ultimately want to achieve but any small steps create a change in the conversations that people have. If you are fortunate enough to have service-wide support from the outset, make sure you understand the operational landscape of your organisation and how this fits.

Issues to do with culture and change management will be more important for such a large project than some of the potentially side-tracking issues within psychology.

I firmly believe that formulation is a tool that can help teams develop a good assessment that leads to a more recovery-orientated culture and collaborative working with the people we help. But everything has disadvantages and it is worth knowing and planning for the ones we know about. Leeming et al. (2009) found that clients felt they had to emphasise the impact of their experiences to reinforce that they weren’t weak/incapable and that formulation can be difficult or embarrassing to share with other people. So we have work to do in helping patients build a narrative that is comfortable to hear and to share.

There are still things to work on and teams fluctuate in their engagement with the process. But there have been various moments when I knew we were making a dif-
Early on I knew we had begun to change how people thought about complexity when an occupational therapy assistant was told by his supervisor to ‘look at what the formulation said’ when he was struggling with a patient; when health care assistants started reflecting on each other getting sucked into maintenance cycles; when external serious incident reviewers have commented that a formulation would have prevented some of the problems that had developed in a team. We have had some lovely single case studies in care homes (e.g. carer strain reducing significantly due simply to increased understanding and some dramatic reductions in challenging behaviour after staff changed their own behaviour).

I do think it has formalised the value that we bring to patient care and protected the value of our indirect work. One very senior, non-psychology manager, in deciding what staff to include in a newly commissioned team, was challenged about having an ‘expensive’ consultant clinical psychologist. Her retort was that she knew the cost of not including one. That sums up how far I think we’ve come.

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References
IN THE JULY issue of CPF David Pilgrim gave a personal take on the earlier chapters in Clinical Psychology in Britain: Historical Perspectives, placing the emergent profession of clinical psychology in its wider sociological and political context. This was followed in the September issue with John Hall’s focus being the evolving roles that clinical psychologists adopted within the NHS. The original vision of the clinical psychologist as an applied scientist working closely with psychiatrists to construct psychometric assessments of psychological functioning soon gave way to the development of psychological interventions based on the application of psychological theories of dysfunction or distress.

I would like to highlight some of the influences that have differentiated clinical psychology from its parent discipline of psychology, and led to its application across diverse clinical problems and populations. Whilst identifying key historical events, I should also like to comment on some of these developments from a more contemporary perspective.

Clinical psychology, academe and research

Within the book’s introductory chapter, we review the growth of psychology as a discipline within the UK, charting its relatively modest origins as an academic subject within UK universities, compared to some of its counterparts in the US and Europe. We evaluate the influence of the British Psychological Society on the evolution of the subject and its differentiation from ‘psychological medicine’ or ‘medical psychologists’, and the direct involvement of the medical profession. At the same time, psychology became further specialised, with the recognition by the British Psychological Society of different branches or divisions of applied psychology. The current success of the academic discipline is captured by its popularity with students (over 90,000 psychology students a year), representing one of the most popular subjects within our universities, schools and colleges. Further accolades for UK psychology can be recognised through the ESRC International Benchmarking Exercise (2011) that identified UK psychology, including clinical psychology in particular, as being genuinely world leading. Finally, the recently published Research Excellence Framework (www.ref.ac.uk/panels/paneloverviewreports) further endorses the quality of psychological research within UK universities.

However, as discussed in Chapter 11 of the book, evaluating the contribution of clinical psychologists to research, most practitioners have neither the opportunities nor the inclination to contribute to clinical research following their training. Indeed, there appears to be a disconnect between the internationally recognised achievements of university clinical academics and the importance attached to research by practitioners or the profession as represented by the DCP. Clinical researchers such as those recognised within the Research Excellence Framework have little presence within the DCP or its publications. Early-career clinical psychology researchers have little in the way of career support compared to their medical counterparts. More generally, there is a massive imbalance in funding psy-
psychological therapies research relative to biomedical or neuroscience research targeting pharmacological interventions (Nature, 2012). Perhaps this reflects the lack of political recognition of our profession, the overwhelming influence of the medical Royal Colleges on healthcare in the UK, and the effectiveness of the ‘Big Pharma’ lobby?

Impacts of clinical psychology for service users?

This raises the question of what the impact of profession’s successful trajectory has been for those individuals who have been the recipients of psychological interventions. In the final chapter we assess the profession’s moral and political agendas in offering these interventions to our clients or patients who are supposedly in need. As Richards (1983) has suggested the profession offers a mix of science and humanism or ‘scientific humanism’ to its employers and clients in order to justify its professional credibility. Indeed, national programmes such as the Department of Health’s multi-million pound investment in Improving Access to Psychological Therapies have drawn international attention to the importance of evidence-based psychological interventions for mental health. Nevertheless, some psychologists have frequently critiqued their own over-emphasis on individual pathology and therapy at the expense of more social determinist explanations of distress, as espoused by writers such as David Smail (see Falconbridge, 2015). Moreover, the history of the profession inevitably documents practices and positions with respect to human rights, and gay rights in particular, which today would no longer be justified or tolerated. Again, we have attempted to draw attention to some of the historical abuses associated with the practice of clinical psychology in the final chapter.

But what of the impressions and judgements of those that directly receive or use psychological therapy services? We have tried to document psychologists’ direct involvement in services as service users themselves, as outspoken advocates for clients, or as colleagues working alongside service users and carers in their roles as ‘experts by experience’ and acting as advisors to charities or professional bodies such as the DCP. Chapter 2 provides an account of clinical psychologists’ influences on the user, and the recovery movement within the UK. Both the contributions of individual psychologists, and the more recent institutional support offered by the DCP to enhance the voice of service users and carers in influencing the development of clinical psychology are considered.

Clinical psychology specialisms and divisions

A major influence on the practice of clinical psychology in the UK has been the profession’s close association with the NHS. Although the work of clinical psychologists is frequently equated with adult mental health, its origins are with those psychologists who worked alongside social workers and child psychiatrists within child guidance clinics. As the numbers of psychologists within the NHS grew, clinical psychologists found themselves working with children and adults within either influential teaching hospitals such as the Maudsley or the Tavistock Clinic, or within large asylums for people incarcerated as ‘mental defectives or lunatics’. However, with the gradual closure of the large asylums instigated by Enoch Powell and the new mental health act of the 1960s, clinical psychologists experienced a wealth of interest from the NHS in their services that extended beyond child and adult mental health or people with learning disabilities. An influential review of the profession by Trethowan, a psychiatrist, identified a range of clinical populations and services (i.e. physical and mental handicaps, child and adolescent health, neurology, mental illness, geriatrics and primary health care) that required the input of clinical psychologists being organised upon a district-wide basis. This constituted a step change in thinking about what clinical psychologists had to offer above and beyond just the assessment and treatment of individual referrals. Trethowan’s vision was how teams of psychologists should be organised within a district department, offering a wide range of psychological services to diverse clinical populations with specialised needs.
These new demands from the NHS to address the specific psychological needs of a diverse range of clinical groups led to the specialisation of clinical psychology and formation within the DCP of corresponding Faculties and Special Interest Groups. Their history is summarised in Part 4 of the book regarding ‘Work with Client Groups’. For some specialities (clinical child and clinical health psychologists) this also included splits and rivalries with other British Psychological Society divisions of applied psychology. Although we did set out to be comprehensive, there are some notable gaps in the narrative, including services for addictions, eating disorders, families and the emergence of psychology services specialising in community psychology approaches. The pressure to specialise and for trainees to be familiar with a range of different client groups (e.g. children, adults, older adults, people with learning disabilities) also resulted in postgraduate training extending from two years to three years around the turn of the last century.

**National and international influences and interactions**

The impact of the NHS on the profession also led to changes in the psychologist’s role and their contribution to the wider NHS, such as training other professions, acting as clinical researchers, and advising and managing services. More recently, changes in the NHS itself across the different devolved administrations in England, Wales, Scotland and Northern Ireland have lead to services evolving in different directions and with different emphases. For many years, health services were centrally driven by Whitehall, whereas now the provision of services across the devolved nations is quite diverse. A good example being the steps taken by Scotland and Northern Ireland to train psychology graduates in roles (e.g. assistants or associates) to support fully-qualified clinical psychologists, echoing Trehovwan’s recommendation of almost forty years ago to develop properly trained psychological technicians. Moreover, different countries have presented psychology with specific challenges ranging from institutional child abuse in the Republic of Ireland to the ‘Troubles’ in Northern Ireland. Part 5 of the book has therefore provided the space to tell the distinctive histories of the profession within the devolved nations of the UK, and also the Republic of Ireland.

It also examines the interactions that took place across international boundaries in the formation of the profession within the UK. Many of the influential pioneers in psychological therapies (e.g. Berger, Eysenck, Meyer, Rachman, Shapiro) actually studied abroad but were attracted to London for a range of reasons both prior, during and after the World War II, where they continued their training and development as psychologists. In contrast, early graduates from clinical psychology courses such as Maudsley were to emigrate to Commonwealth Countries and establish clinical psychology services abroad. More recently, clinical psychology programmes have been involved in training students from countries outside the UK due to the provision of government studentships and international scholarships. This has also resulted in staff from UK training courses helping to establish or facilitate programmes in countries as diverse as Bangladesh, Jamaica, Japan, Pakistan, Spain, Sri Lanka, Tanzania, Uganda, etc. This rich intellectual and cultural exchange is dealt with also in Part 5.

We trust that these three brief articles have wetted your appetites for reading further about the history of our profession. We also hope that a critical history of the profession might be the catalyst for a fresh review of the profession and the DCP going forward into its fiftieth year. The book will be launched in December at the DCP Annual Conference in London, and critically reviewed within a specially invited symposium preceding the book launch.

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ON BEHALF of the Division of Clinical Psychology, Alex Stirzaker, England’s IAPT National Advisor for SMI (Severe Mental Illness and Personality Disorder) has taken on the task of forming a new commission with the purpose of improving access to appropriate health services for people diagnosed with a ‘personality disorder’ or who would attract this diagnosis if they accessed or were not excluded from services. It’s been a long time since 2003’s Personality Disorder: No Longer a Diagnosis of Exclusion was published by the National Institute for Mental Health for in England. However, many people do not have access to any psychological or social help and despite some advances in provision over the years, services are still some way off where they need to be for this client group.

The commission will report on the current clinical and operational position across the UK for those diagnosed with ‘personality disorder’, including all people across the lifespan, and across all services. In partnership with Rethink, MIND, the Royal College of Psychiatrists, NHS England, the Royal College of Nursing, Emergence, National Survivor User Network and others, the commission will collectively review the evidence base, seek views from their members and act as advocates for this client group for changes to current service provision.

Kerry Beckley (Chair of The Faculty of Forensic Clinical Psychology), Andrew Hider (Psychosis and Complex Mental Health Faculty (PCMH)) and Rai Turton (Faculty for People with Intellectual Disability), join Alex in this work alongside other PCMH committee members, and over time the Commission will seek to work with all the divisions and member networks of the British Psychological Society. To Chair the Commission Alex has secured the commitment of Norman Lamb MP, Liberal Democrat Health Spokesman and Former Minister of State for Care and Support. A significant development is that the commission is designed to be co-led, 50/50, with experts by experience. The commission is fully supported by our President Jamie Hacker Hughes, and President Elect Peter Kinderman will also sit on the panel. On joining the commission Peter said: ‘This will be an opportunity to address, with colleagues, and in a measured, evidence-based way, all those contentious but important issues. It’s worked well for the ‘schizophrenia commission’ and, before then and in a different format, when the Department of Health looked into appropriate therapies for people with depression and anxiety, so this is an opportunity to make a difference. I’m delighted that the Society is again taking the lead here.’

Language is tricky here. Most people are used to the short hand of ‘PD’ even if they don’t particularly like the phrase. Feedback from service users is mixed, with some finding the presence of a diagnostic term validating, whereas others find it unhelpful. The Society and DCP have published position statements critiquing classification of behaviour and experience in relation to the use of functional psychiatric diagnoses. However, the commission’s focus will be broad and would see decisions about appropriate terminology as a matter for discussion between service users and members of all disciplines. Pending the adoption of any alternative terminology, the commission will pragmatically continue to use the term ‘personality disorder’, although we would encourage the use of quotation marks when referring to ‘personality disorder’ to reflect the contested nature of the term.

Psychologists are often clinical leaders in the delivery of treatment for this group of people and the NICE guidelines for all types of problem that fall under the use of the term advise that psychological treatment and psychologically based care are the mainstays of intervention. Therefore, the commission will summarise and develop the argument for the provision
and commissioning of effective psychological interventions and psychologically informed mental health systems. It will help develop internal and external policy development at a national and local level by influencing commissioning and supporting the transformational changes currently being planned in organisations such as the NHS and within the criminal justice system. The commission will help to identify the workforce requirements going forward in order to develop the competencies of staff who provide services to this group.

PCMH has summarised its core role in the commission’s work as follows:

- To provide professional guidance on detection in order to support commissioning and resource allocation.
- To make transparent the clinical input that is being provided across all four nations to this group, across all sectors, including all tiers of health, social care and the secure estate broadly (prisons, probation and forensic services).
- To seek to reduce stigma and call for a perspective on ‘PD’ that is more person centred and recovery focused and, in connection to this, to ensure that outcome metrics (and therefore commissioning) follow these principles.
- To support self-advocacy.
- To support a multidisciplinary and multi-agency approach to people requiring services.

There’s a lot of work to be conducted, particularly on how all disciplines can identify those in need and systematically offer accessible, effective psychological services across the UK. At this stage if you have any examples of good practice you would like to share, particularly ones that fit with the core role PCMH are taking, please do forward them to Linda Wilkinson, PCMH Acute and Crisis Co-Lead (Linda.Wilkinson@shsc.nhs.uk).

Further updates with information on how DCP members can be involved with the Commission will be given as the work progresses.

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Notes from the Chair

Headlines from the most recent Executive Committee meeting

Richard Pemberton

We were joined for part of the recent DCP Executive Committee meeting by the Society’s President, Jamie Hacker Hughes, who updated us on the Society’s structure review, and by the Society’s Director of Member Services, Helen Clark, who briefed us on the Society’s new recom pense policy. Minutes of the meeting and all the papers mentioned below can be found on the DCP website (www.bps.org.uk/dcp). These include the recom pense policy, details of the educational and clinical psychology training review, the inclusivity strategy, the terms of reference of the personality disorder commission and the slides from the pre-qualification group presentation.

British Psychological Society restructuring
When the member networks review was set up, we argued unsuccessfully for the division to have a seat on it. Dee Anand, Chair of the Division of Forensic Psychology, represents all the divisions. Jamie confirmed that none of three options for change that were circulated to members had gathered much support. Members are in favour of significant change, but do not want to lose their current structures. As the review of educational and clinical training has demonstrated, there is a need for more joined up arrangements and an informed debate about differing divisional areas of expertise and competency.

Our division is by far the largest and many of the proposals floated thus far seem to want to build on the strengths of our faculties. A new set of proposals for change will be discussed at the Society’s forthcoming General Assembly. Despite our faculties being larger than some of the other divisions, special groups and branches, they are not represented at the assembly. We agreed that we would press for change in the way the review is being conducted and for representation on it to be rethought.

If more proposals come out which don’t garner any significant support then the momentum for much needed change will be lost. The division is well placed to help drive change, but can’t do this from the sidelines.

Elections and the new recom pense policy
The Society has now drafted a new recom pense policy. The policy is out for consultation. On the basis of the briefing that we received from Helen Clark, we resolved reluctantly to again postpone executive elections.

The new policy has had to try and balance employment, charity and taxation law. In the division we currently recom pense 2.9 WTE posts. This does not seem profligate when we have over 10,000 members. The indication is that the trustees want to reduce the number of our posts that are recom pensed. Of particular concern is the proposal to backfill posts at a lower level than the substantive grade, which would effectively rule out backfill payments above Band 8C. The new proposals will also rule out altogether payments to sole traders. This would be problematic given the increasing number of members moving into independent practice.

A number of senior and highly regarded figures in the profession have indicated that they are planning to stand in the next round of elections. If the new policy as outlined is implemented, it may be problematic for them to stand.
Notes from the Chair

It is clearly constitutionally highly unsatisfactory to delay our elections yet again, and it is asking a lot of the current leadership of the division to continue in their positions whilst this is being resolved. The executive wishes the elections to be held as soon as possible. Realistically, the earliest this can probably be is February/March 2016.

This is a complex matter and one which we will want to consult members about. We have been working hard to strengthen the leadership of the profession at all levels. If we cannot continue to attract our most senior members of the profession into key leadership positions then we are going to have to think very seriously about what we do next.

The educational and clinical training review
Despite a near universally negative reception in clinical psychology to the suggestion that the training of clinical and education psychology is combined and adult and child clinical psychology training split, the Department for Education seems to be continuing to keep this proposal alive. We have been stepping up our efforts to block this ill considered development and have been getting support from within Health Education England and from senior NHS England figures. We are continuing to work closely with the Society and the Division of Educational Psychology as we are of course very interested in helping to improve access to psychology services to children.

Inclusivity strategy
The lack of diversity in the profession is a serious problem. This has been a particularly challenging area. In this context it was particularly pleasing to sign off the new Inclusivity Strategy. The strategy sets out an ambitious agenda which includes: CPD events, monitoring, mentoring, awards and outreach. Many thanks to Stephen Weatherhead who has built this strategy from the ground up. The Executive Committee agreed to the establishment of an inclusivity outreach officer to help get the new strategy up and running across the profession. An event to formally launch the strategy will be advertised shortly.

Personality disorder
… or as Geraldine Strathdee, NHS England Clinical Director for Mental Health, prefers to call it, ‘complex trauma’.
We agreed to part fund a new Personality Disorder Commission that has been established with MIND. It will be chaired by Norman Lamb. We will have three division representative seats on it and three places for our experts by experience.

Pre-Qualification Group
Last but not by no means least, Anita Raman and James Randall gave a great presentation to the Executive Committee on the work of their group. The groups goals are: to promote active involvement in the development of the profession of clinical psychology at pre-qualification level; to represent the voice of future clinical psychologists to key stakeholders; to provide and invigorate professional development that is relevant to pre-qualification stage; and to provide a positive and supportive professional network to those on the journey to becoming clinical psychologists.

This is a really important group, given the problematic obstacle course that people wishing to train have to endure prior to application. Through a range of CPD events and outreach they have, over the course of the last year, managed to increase the number of division members in training up from 15 to 20 per cent and for those applying for training up from 20 to 30 per cent. They now have over 1600 members and plans in place to build on their success.

Richard Pemberton
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Formulation meetings in a Tier 4 child and adolescent mental health service inpatient unit

Gordon Milson & Katy Phillips

In this article we discuss how the work context has influenced the process of establishing formulation meetings and continues to affect our practice. We also reflect on the ongoing challenges and opportunities that these meetings present.

PENNINE CARE NHS Tier 4 child and adolescent mental health service (CAMHS) is split into two adolescent inpatient wards: the Hope Unit, an acute ward which aims to follow a six week care pathway from admission to discharge, and the Horizon Unit, a treatment ward where admissions range between 6 and 18 months. Hope has ten beds and Horizon has twelve. Both wards are staffed by multidisciplinary teams where everyone plays a key role in continued service development and ensuring clinical effectiveness while working with young people with some very challenging presentations. There is a part-time (0.5 FTE) clinical psychologist, and a part-time (0.5 FTE) assistant psychologist on each of the wards. Though the units share much in common, the acute focus on Hope Unit and the longer-term rehabilitation and therapy focus on Horizon Unit mean that there are contextual differences that require slightly different structures and processes.

The key challenge on Hope Unit is to return the young person to the community as soon as possible. The focus is on intensive assessment and work with the young person and their systems to ensure a collaborative, shared understanding is developed. Risk is a crucial part of the formulation and systemic factors involved in the dynamic of risk are central to thinking.

The key aim on Horizon ward is also to discharge a young person from hospital in a timely and safe way. An additional challenge is to develop and maintain positive working relationships between them and the staff over a long duration in a closed environment. Formulating ongoing relationships is central to this and has been shown to improve staff and service users’ experience of the relationship in inpatient settings (e.g. Berry et al., 2009).

Establishing team formulation meetings

The clinical psychologists on both units routinely brought psychological formulation into ward round discussions about young people’s progress, but became aware that this did not always result in formulation-driven interventions. Therefore it was decided that a separate space was needed to develop a collaborative team formulation with key members of the care team. This idea was discussed with senior team members and the DCP (2011) Good Practice Guidelines on the Use of Psychological Formulation was used as the basis for recommending establishment of these meetings, and it was agreed that they would be set up and evaluated.

As with any new initiative in an established setting, formulation meetings took time to become part of the functioning of the wards (Down, 2010). Both wards trialled meetings but these were initially seen as low in priority and were poorly attended. Timetabling them to follow ward rounds, which are the main multidisciplinary team meetings on the ward, allowed for greater engagement and prioritisation.

Involving young people in the process of developing a formulation has been a key aim.
Management support was a key factor. This led to the development on Hope of a care pathway which timetabled formulation meetings a week before a care programme approach meeting to allow for a coherent approach and for understanding to be shared with other professionals, family members, and most importantly, the young people themselves.

The current process
The team formulation meetings are attended by members of the young person’s care team including staff nurse(s), nursing assistant(s), doctor (staff grade or consultant psychiatrist), occupational therapist, family therapist and the clinical psychologist, and are scheduled to last for one hour.

On Hope Unit, information and views from the community team are shared, followed by assessments undertaken by the ward team. Structured assessments with families or carers based on systemic and developmental principles are discussed in the meeting. Key questions are: What led to this young person needing to come into hospital? What needs to happen to assist them to leave the ward? What are the obstacles to discharge? What is the plan for managing risk? What is the plan for transition back to community teams? This results in a working formulation summarising these areas.

Involving young people in the process of developing a formulation has been a key aim on both wards. The formulation meetings include discussion of reports and observations made by the young people themselves – although they are not present because of the need to allow staff a space to reflect together. Afterwards, the clinical psychologist uses the team’s brief working formulation to develop a formulation letter with the young person. They can share this with the family/carers, community team and anyone else they choose. However, it is only shared with their permission. Aspects or details they may not wish to disclose are removed.

The letter is often developed in collaboration with members of the nursing team and addressed from the team rather than an individual, although the psychology team retain leadership in this process. This is to ensure that all assessments and information are utilised in the development of the formulation and to support a consistent approach from the entire ward team.

The Horizon team uses the weekly team formulation slot to prioritise developing an initial team formulation for a young person between admission and their first care programme approach meeting. These meetings take the format of a team discussion that seeks to integrate information from multidisciplinary team assessments with observations and reflections on current interactions. The language of the young person is used wherever possible. Attention is given to their view of their personal story, elicited through timeline work in one-to-one sessions prior to the meeting. Relevant theoretical models are used to help make sense of the information presented. The clinical psychologist who facilitates the meeting sketches out a diagram based on the four Ps (Predisposing, Precipitating, Perpetuating and Protective factors) (Weerasekera 1996), ensuring that the personal meaning of relationships and life events is included. This then serves as a record of the discussions and as a prompt for sharing the information with the rest of the team and in future ward rounds.

Discussion then focuses on how this understanding might guide care and therapeutic interventions. The following questions are used as a guide to help this process:

(i) What has been the experience of working with this young person so far?
(ii) What do we need to find out more about?
(iii) What might be the challenges for the team?
(iv) What works well? What helps? What might be helpful?

Thinking specifically about the challenges for the team allows us to bring ourselves, the team and wider systems into the formulation as well. For example, the impact of recent changes to staffing on relationships might be considered. When there is no new admission, reformulation meetings are held in the same weekly slot; thus, formulation slots are consistently part of the weekly timetable.

Ideas from the Horizon team formulation meeting are taken into subsequent one-to-one formulation development sessions with the psychologist. It is emphasised that only the ideas that fit for the young person should be
included and that these might change over time. Feedback from one-to-one sessions and the team formulation meeting are subsequently incorporated into therapeutic formulation letters by the psychologist. Young people are given a choice about whether or not they would like to receive such a letter and with whom, if anyone, they would like to share it.

An attachment perspective
One of the key challenges within inpatient settings is how to work therapeutically with large staff teams. The clinical psychology team uses attachment-based theory and practice to inform their roles, as a basis for helping to understand the needs of children and young people who often present with high levels of distress and dysregulated emotion. This attachment-focused approach highlights the importance of establishing a consistent, predictable way of working with a young person, and formulation is a powerful clinical tool for facilitating this.

The young people in our service have often become very disconnected from different aspects of their lives. Family relationships have become strained, education attendance is often adversely affected and other personal relationships have often been severed. A common theme is feeling that no-one understands and that they are alone with their distress. This can be a barrier to accepting support from others. The process of formulation results in what we call ‘shared understanding letters’ to the young people. These can be shown to people the young person would like to re-connect with or develop a greater connection to, including family members and CAMHS staff.

An important theme in formulation meetings is the role of the team in that person’s distress and how we can avoid maintaining negative cycles of interaction. Many of these young people have experienced trauma, often relational, so this is central to the discussions.

The relationship between diagnosis and formulation
Hope and Horizon are both hospital wards, and service users often have difficulties that present a very real threat to physical health, including severe self-harm and prolonged starvation. Consequently, certain medical situations need to be prioritised. The rationale for use of the medical model in this context is understandable, but can leave little space for different ways of talking about and understanding distress. Recognising this, and consistent with incorporating different types of information from multiple sources, the language of psychiatric diagnosis is used within a formulation when it is meaningful to the young people and their families, and/or to the team. The preference of the young person is always sought; if they state that they would like to be given a diagnosis then this is discussed, and if they do not, then formulation can be an alternative. However, diagnostic terms are always ‘fleshed out’ with added context, consistent with the Leadership Framework (DCP, 2010). The aim is to develop a biopsychosocial formulation which includes life events and personal meanings.

In practice, all the young people who use these services are given a diagnosis and a broad treatment plan based on NICE guidelines, following initial assessment. Team formulation meetings are central to offering person-centred care within this context and provide a basis for integrating a range of therapeutic interventions. Team and individual formulations are used as an opportunity to offer an alternative framework to diagnosis.

Evaluating the impact of formulation
The impact of formulation meetings has been measured on both wards in different ways reflecting the different contexts.

Hope Unit: Experiences of young people
The Hope Unit have been evaluating young people’s experiences of the process of developing formulation letters. This is an ongoing project in which young people complete a questionnaire about their experience of taking part in the process of formulation and sharing the letter. A sample of typical comments received to date appears below:

‘It feels like the letter was easier to use to communicate and evaluate the things we spoke about and to see clearly how the things that we talked about were interpreted.’
‘It’s good to have it summarised and together
and it shows me people understand how I feel, which is important to me.’
‘I understand how the team perceive what’s happening and that they understand; it shows they were listening.’
‘Thank you, it really made me feel better about the fact people understand.’
‘It helped me realise that someone actually does know what’s going on for me.’
‘It helped me realise how far I’d come and the progress I’d already made.’
‘It was personal and addressed to me, not just a few paragraphs about me, which I thought gave me a different view and overall feeling.’

Horizon Unit: Experiences of staff

A pilot evaluation of staff members’ experiences of team formulation meetings is being carried out on Horizon using the Team Formulation Questionnaire developed by Hollingworth and Johnstone (2014). Fifteen staff members, reflecting the full range of multidisciplinary team professions, have completed the questionnaire to date. Seven respondents added additional comments in response to prompts:

‘It allows me to examine my views of clients, gauge other people’s understanding, tolerance and passion to help clients.’
‘Great for sharing knowledge – giving a better understanding of the origins of malignant behaviours.’
‘Allows all to share knowledge gauged about individuals which might go undiscovered without such events.’
‘I’ve really benefited from attending team formulation to help feel supported by the team when working with challenging clients. It has definitely helped me to develop a better understanding of the clients and brought together the therapeutic work.’
‘…there are some challenges around sharing the formulation with the wider team to enable this [creating a more coherent therapeutic approach towards clients] to happen.’
‘It has been really useful and would be great to get more staff into the session.’

These responses indicate that staff feel the meetings increased understanding of the young people, improved knowledge, and also provided support. However, there is still a need to think about how formulations are shared with the wider team and integrated into ward protocol and how to encourage more team members to attend.

Ongoing challenges and opportunities

A key challenge is to ensure that formulation and reformulation remains a dynamic process so that there is a clear message about the possibility of change. Space for re-formulation, whether in one-to-one sessions or as a team, needs to be available. Both wards continue to reflect on how this can best be achieved.

The young people who use our services have often had many prior relationships with other services, including other inpatient services and community CAMHS. Formulation meetings offer a chance to reflect on the beliefs about the helping process that young people and staff members bring (e.g. Reder & Fredman, 1996), something that might otherwise be forgotten.

The teams on both wards are keen to continue developing skills at formulating as a team and are looking ways of doing this. The Horizon team has just started to use the Case Formulation Quality Checklist (McMurran et al., 2014) as part of a pilot to evaluate the quality of previously developed formulations and as a way of assessing the developed formulation at the end of each meeting on Horizon ward.

Producing a collaborative team formulation (i.e. young person and team) is arguably a greater challenge than developing a collaborative formulation in the more traditional sense (i.e. young person and one therapist) for a number of reasons. There is limited staff availability at times due to competing priorities, and the number and variety of perspectives within the team can seem overwhelming. Furthermore, whilst a reflective space for team members is important, there is a need to keep the young person at the heart of the process.

Authors

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Study into clinical psychologists' experiences of running team formulation meetings

Investigators: Katie Wood, Dr Jason Spendelow and Dr Kate Gleeson, Psychology Department, University of Surrey, Stag Hill Campus, Guildford GU2 7XH and Dr Lucy Johnstone, Cwm Taf University Health Board

Researchers at the University of Surrey are interested in hearing from clinical psychologists who are willing to share their experiences of running team formulation meetings.

Whilst team formulation is an increasingly adopted practice, there is still a limited amount of research on how they can be implemented most effectively. One of the suggested benefits of team formulation is to promote psychosocial explanations of mental health difficulties in multidisciplinary teams; however, much of the existing literature alludes to issues with negotiating staff attitudes towards team formulation. A greater understanding of how clinicians are using team formulation and how issues are being negotiated in practice will allow clinicians to learn from each other and inform best practice guidelines.

This study will involve participating in an interview with a researcher (either in person or over the telephone), which will take approximately 30 minutes. All information will be treated as strictly confidential and only anonymised excerpts and summary data will be published.

The study has been approved by the University of Surrey Faculty of Human and Medical Sciences Research Ethics Committee.

To find out more or take part, please e-mail Katie Wood on k.m.wood@surrey.ac.uk
Optimising team formulation to promote effective team care

Patrick Roycroft, Samantha Man, Ewa Downie, Stephanie Gale, Nicola Armstrong, Leanne Page & Michael Humes

We developed a standard biopsychosocial formulation framework for our inpatient teams. Our data suggest that this has helped all disciplines within our teams to work together to create intervention plans based on an understanding of the individual’s strengths and needs.

For many years, inpatient services at Northumberland Tyne and Wear (NTW) Trust have aimed to provide a biopsychosocial approach to care to reflect the role that the full MDT – comprising psychiatry, psychology, nursing and occupational therapy – can play in helping people with complex needs.

Our inpatient services include around 10 rehabilitation units which specialise in working with people whose needs are often complex and long-term. Over 80 per cent of service users have been diagnosed with psychosis. It is not unusual to hear terms such as ‘treatment resistant schizophrenia’, and for those accessing the services to have had multiple or extended inpatient stays.

Historically, input from psychological services on many of these units, although high quality and valued, has been provided by community-based staff offering just a session or two a week. Many nurses, occupational therapists and psychiatrists have provided access to psychological approaches without robust training, support or supervision. Despite this, inpatient staff have often developed high levels of skill in engaging and working with people in severe distress – the emphasis frequently being on stabilisation and gradual rehabilitation.

More recently, as our inpatient services have contracted in size, we have aimed to make them more therapeutically powerful by ensuring increased access to recovery skills and change-focused psychological approaches over shorter admission periods. This has been supported by trust-wide investment in two key areas.

Firstly, the Trust has set an aim of establishing a minimum of five sessions of psychology input per unit, with similar aims for occupational therapy. This enhances the levels of psychosocial treatment, supervision and attendance at inpatient team meetings – turning them into MDT meetings, with a fuller range of staff, more able to work across the biopsychosocial spectrum.

Secondly, NTW prioritised the need to build on the significant psychological skills of our frontline staff across inpatient and community services. Trust-wide training programmes have been provided for several hundred frontline staff using a competence-based approach (Roth & Pilling, 2007) to psychological skills training – often provided in-house by psychological services staff and supported by follow up supervision from psychologists and therapists. We focus here on the cognitive behavioural therapies programme of NICE-based approaches to common problems like anxiety and depression via graded exposure and behavioural activation, and based on functional analysis principles (Reeves & Stace, 2013).

These changes presented not just opportunities but also challenges for the inpatient teams in taking on board new members to create a full MDT, and in integrating psychosocial intervention techniques with their associated new ways of understanding and formulating problems. How could MDTs apply these techniques alongside hard-won established skills, and with service users whose presentations challenge the effectiveness of these approaches?
While NICE guidelines serve a unifying guiding function for many services, for our services users the level of complexity of presenting problems means that their application is limited. With fewer guidelines available the potential for conflict between biopsychosocial approaches is higher. As in most healthcare settings, most of the time clinical staff manage these tensions for the sake of providing the best service they can for service users (Milson, 2014) and many teams evolve their own approach to team formulation – but this often evolves without explicit discussion or reflection, as was the case across our units.

We were aware that evidence suggests that teams using less well-defined approaches can become less effective (West, 2012). An unstructured team meeting in a team dealing with high levels of risk and distress can raise the danger of splits or defensive practices. We were inspired by practice-based evidence generated by teams within our Trust, who also rely on whole team approaches, particularly within Older Adults and Learning Disabilities (James et al., 2007, Ingham et al., 2008).

There is emerging evidence that staff see the development of a shared, agreed and clear team formulation format as contributing to better team care planning, better relationships with service users and more confident and optimistic treatment approaches – the glue that holds an MDT biopsychosocial approach together (DCP, 2011). We wanted to create an agreed framework for rehabilitation services that was biopsychosocial, reflecting the needs of our service users. We wanted it to help the whole team to integrate new approaches and to support communication with other teams.

**Team formulation: What and how**

There is no universal definition of formulation, either within the psychology professions or amongst our MDT colleagues. Research into the reliability and validity of individual psychological formulation is at an early stage, with researchers calling for a focus on formulation as a process (Kuyken et al., 2009). For these reasons we formed a Team Formulation Steering Group representing all the MDT professions, and we defined MDT formulation as a process of developing an understanding of the service user’s difficulties and strengths, constructed and agreed by the whole MDT within a biopsychosocial framework. This is in contrast to leadership by a single profession, as in teams working within a purely psychosocial or purely medical framework. Team formulation is not a substitute for an individual formulation that might be developed in therapy, but is another tool to complement the overall assessment and treatment delivered by an MDT.

We decided to adopt the use of a 5Ps plus Plan model – Presenting, Predisposing, Precipitating, Perpetuating and Protective Factors plus Plan (Rutter, 2015) because it provides a coherent structure which is already used across disciplines. Our Trust information systems require diagnoses to be recorded separately, and these can also be included within a formulation where a team has established the validity and utility of its inclusion for that service user. It is recognised that service user engagement in this process is crucial, and the focus on problems and strengths can enable a degree of shared purpose where agreement is not established.

We agreed on basic principles based on the best evidence bases available for formulation and for team functioning (Kuyken et al., 2009; DCP, 2011; West, 2012):

1. The content of MDT formulation should be biopsychosocial. Biological, psychological and social factors are all considered, which allows different disciplines’ formulations to be integrated and co-ordinates the use of recovery plans, care plans and risk assessments.
2. The MDT formulation should recognise different levels of explanation. The 5P framework describes levels from a description of presenting problems, through factors that trigger (precipitate) and maintain (perpetuate) to long-term predisposing levels. This was recognised by the MDT steering group as being useful for summarising factors from biopsychosocial domains and for helping staff to plan interventions. It allows frontline staff who have learnt functional analysis as part of their in-house CBT...
training to place this in the context of a broader understanding of the person.

3. The MDT formulation should focus on resources/strengths as well as stress/vulnerabilities. The framework includes stresses and vulnerabilities but also links to strengths, resources, resilience and recovery through the protective factors section. This integrates recovery approaches with the positive psychology approaches which have an emerging evidence base (Frisch, 2013).

4. The MDT should employ a collaborative approach to testing ideas, involving the whole team.

The emphasis on formulating as a process rather than on formulation as a finished product allows a team to recognise and change their ideas, and to recognise service users’ ideas as well.

MDT formulation: Training and development programme

We prioritised the development of MDT formulation as a cornerstone of the workforce strategy. As part of this, we developed in-house training, which was delivered to whole teams wherever possible, by trainers with at least two disciplines represented. The formulation development programme aimed to model and encourage team processes consistent with the evidence base for effective MDTs (West, 2012) (i.e. to encourage debate, integration, listening to and testing out of different ideas, and the constructive holding of differences in opinion).

Since 2013, over 150 staff have attended the formulation training. A sample of the feedback based on 44 questionnaires indicated that it was very popular: 100 per cent of staff said they would recommend it to colleagues, felt satisfied with the training and thought it helped improve their understanding of formulation. Feedback also indicated that staff wanted more regular formulation meetings and more staff to be trained, and valued the inclusion of staff at all grades.

Participants were asked what impact the training session had had on their understanding of a person’s problems. The responses recorded in two randomly selected sessions included statements such as: ‘Shows how important it is to realise how close the protective can be to the perpetuating factors’; ‘Makes you think about where to intervene’; ‘Realise not everything is a problem, it may not be seen as a problem by the patient’; ‘Helps understand the problem better – less likely to put a label on it – makes you think how things lead towards that’; ‘How we can play a part in maintaining the problem’; ‘Good picture of the person not just the mental illness’; ‘Can help with managing challenging behaviours – helps bring back focus to the team’.

Evaluation of MDT formulation

Once MDT formulation had been established on our units we wanted to evaluate the quality of the process and also consider the acceptability to the teams longer term. A survey on one of our high dependency units (Thyoka & Downie, 2015) indicated that staff from all professions and grades reported that the structured formulation format helped them better understand the needs of service users on the unit.

The steering group identified the items from the Good Practice Guidelines for the Use of Psychological Formulation (DCP, 2011), which were most relevant to the MDT meetings on the wards, and developed a tool to measure the content and process. For each item we developed a descriptive grid to support scoring, based on a five point Likert scale. The final tool included 30 items and was piloted across five of the units where training had taken place. Unit managers agreed for two members of the steering group to attend two randomly selected MDT meetings unannounced in order to measure the inter-rater reliability of the tool.

Development of the tool is ongoing, but initial use suggests that inter-rater reliability improves with use and already reaches acceptable levels of agreement. Three main areas of strength of the formulation meetings were identified:

1. Inclusivity of the full MDT, indicated by high scores on items such as ‘All present were encouraged to be active participants’ and ‘MDT views were listened to and respected’.
2. Person-centred approach to understanding service users, indicated by high scores on items such as ‘Discussion takes a non-blaming stance towards service user’, ‘Includes service user’s strengths and achievements’, ‘Is person specific not problem specific’, ‘Is culturally sensitive’, ‘Is expressed in accessible language’.

3. Leads to development of treatment plans, indicated by high scores on items such as ‘Provides a basis for making decisions moving forward’, ‘Clear action plan is developed’, ‘Clear links between information available, discussion and interventions proposed’.

Areas for development included: ‘Linking between formulation, risk assessment and recovery star’, ‘Using formulation to set goals with client’ and ‘Identifying a clear Chair’.

How successful is this formulation approach for our MDTs?
Data about the training from the single unit survey and from observation across different units suggests the formulation approach is not only acceptable to the whole MDT, but that it also promotes involvement of the whole MDT in a process of understanding our service users’ needs and strengths and co-ordinating care plans. Some of the data has been gathered two years after the training and indicates that MDTs are not only still using the structured approach, but are enthusiastic adopters and adapters.

While carrying out observation of content and process the observers noted that the approach promoted the co-ordination of NICE-based frontline psychological interventions like behavioural activation, which had been delivered by the trust-wide training. The MDTs are already planning further skills development using the 5P formulation approach to integrate approaches to working with other problems, such as drug abuse.

The observers also noticed that the approach powerfully promoted the discussion of a fuller range of psychological approaches that are essential for working with people with more complex problems.

The predisposing factors section encourages recognition of the role of trauma in the development of some experiences of psychosis, and the protective factors section promotes thinking about how to focus on service users values and strengths, which are important in setting resilience building goals, and can be overshadowed by a tight focus on problems and distress reduction (Kuyken et al., 2009). Our observations also suggest that the whole MDT is included in formulation meetings. Encouraging support workers, who spend significant time with service users, to contribute, as well as senior consultants and leads, allows a space for the whole team to reflect together with appropriate support, and to challenge its own processes in a constructive way. These frontline staff already employ their understanding of concepts such as roles and schemas. The structured formulation approach recognises this and provides the rigour and feedback of specialist psychology supervision.

This broader formulation, achieved by including the perspectives of frontline staff, can enhance the kind of understanding necessary to strengthen therapeutic alliance crucial to all therapies. It can also help the team to decide when to try stabilising interventions to address processes of problem maintenance and building strengths, and when the aim could be for more challenging interventions such as graded exposure.

Formulation: Further research and development

Developing standards and tools to evaluate formulation
Evaluation is at a very early stage, without baselines or control conditions, but it provides some encouraging data on which we can develop more rigorous research on MDT formulation. The observation tool is promising and needs to be developed further to overcome issues like bias by raters who were also involved in the development of the tool, and other reliability issues. A follow-up project will update and shorten the tool so that it is more reflective of the formulation process, and will consult more widely with the MDT about content and acceptability.
Standardising formulation to aid communication between teams

Within our rehabilitation units, the standard format allows a formulation to travel with a service user, who may move from a high dependency to a step-down unit. Our Trust colleagues in Urgent Care Inpatients and elsewhere have evolved different formats based on similar principles of collaborative empiricism. Community services, who rely more on individual team members to provide treatment, are also using formulation training to standardise within and between team communication. Our Trust is now piloting a formulation approach trust-wide by embedding it within the clinical software used by all staff.

Linking team and service user formulation more effectively

We need to recognise that anything powerful can potentially have negative consequences, particularly if done without due care. Sharing a formulation, like diagnosis, can have powerful effects, negative as well as positive, such as the experience of distress/intrusiveness (Redhead et al., 2015). We have seen poor examples of formulation that consist of problem lists with little recognition of strengths. The negative effects of a poor formulation presented to a service user as being agreed by a full MDT could be even more pronounced. The process needs to be negotiated carefully, continuing to recognise and value the need for the MDT to have a confidential space for discussion, as well as recognising the value of formulating jointly with service users in innovative ways (Clarke, 2009). Team formulations are routinely shared with service users and carers, and users, carers and service user reps are enthusiastic and influential on the steering group. Further projects are planned, to explore the perspectives of all parties.

Emerging practice-based evidence such as ours suggests that structured formulation can focus the team’s mind in powerful ways. Further investment is needed to explore the potential outcomes for service users, and to co-ordinate good practice standards at a national level.

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Acknowledgements

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Team formulation in a secure setting: Challenges, rewards and service user involvement – A joint collaboration between nursing and psychology

Ruth Lewis-Morton, Lee James, Katie Brown & Andrew Hider

The challenges and rewards of using team formulation and the potential dilemmas in achieving true service user involvement are explored in this article. Key themes are illustrated with data from a qualitative study of twelve staff members working within a secure setting in South Wales.

Despite common assumptions that the principal characteristic of secure and forensic care is coercion and containment, it is difficult to imagine working as a clinician within a secure inpatient setting without the ability to reflect and formulate within a multidisciplinary team. Modern models of psychological intervention stress the importance of systemic work (Fonagy & Bateman, 2006; Ryle & Kerr, 2002). For the staff team on a locked rehabilitation unit, the use of weekly team formulation sessions is an integral part of the ward milieu.

Twelve members of the unit team were invited to explore their experience of team formulation sessions through qualitative feedback. Open questions were used in order to promote exploration and reflection, with specific reference to the challenges and rewards of team formulation. Qualitative feedback was analysed by the nurse and psychologist leading the survey and a thematic analysis was used to elicit patterns within the data. This article has been structured around the following topics, with key themes arising from the data used as illustration:

1. What are the challenges of engaging in team formulation?
2. What are the rewards of using team formulation within secure settings?
3. How do we address the dilemmas surrounding true service user involvement in team formulation?

Challenges of using a team formulation approach

Due to the high levels of complexity within inpatient and secure services, complex psychological phenomena such as parallel process, projective identification and repetition compulsion are often played out between service users and the staff team (Bloom & Farragher, 2011).

The concept ‘parallel process’ has its origins in psychoanalytic theory and was first conceptualised by Searles (1955) who described it as a ‘reflection process’ originating between service user and therapist and becoming re-enacted within the supervisory encounter. Within the context of an inpatient setting the term parallel process typically refers to repeating patterns or enactments of relational dynamics within the staff team that originate in the relationship between service user and staff members.

Projective identification also originates in psychoanalytic theory and was defined by Melanie Klein (1946) as an unconscious process whereby aspects of the self (unwanted emotions or intolerable states of mind) are attributed to another person; this is often referred to as projection. The recipient of this process is related to as though they have embodied the attribution and they may be coerced into feeling or behaving in accordance with the attribution, and this, in essence, is identification with the projection.

A key concept used to understand complex trauma and associated patterns of relating is ‘repetition compulsion’, a construct articu-
lated by Freud in his 1914 article ‘Remembering, repeating and working through’. The premise of this concept is that traumatic experiences that are repressed (unconsciously forgotten) may be acted out or repeated without the person having awareness of their role in this repetition.

These complex processes are common within inpatient settings, though at times services’ tendency can be to minimise their impact, and sometimes to contain it in discussions between senior clinicians. This can be referred to as a ‘goldfish bowl formulation’, where psychologists, psychiatrists and senior nurses comment on relational dynamics from the outside, excluding the input of support staff, who can be seen as passive ‘vessels’ of parallel process. A team formulation model adopted at the locked rehabilitation unit referred to in this article has taken the approach of empowering the whole staff team to reflect on and consider these phenomena.

Reservations about engaging with team formulation sessions may be due to fear of what may happen if we actively connect with our emotional responses at work. Reflection can provoke feelings of vulnerability, anxiety and uncertainty. Perhaps the following quote from Marilyn Vanderbur captures what this may feel like for some staff members unfamiliar with team formulation and reflection: ‘To be in touch with my feelings would have meant opening Pandora’s box’ (Vanderbur, 2003, p.98). A lack of awareness of the importance of recognising our emotional experience can facilitate a culture that favours the down-regulation of emotional experience and therefore reduces capacity for reflection, which in turn can further exacerbate problems within mental health systems.

Feedback from the staff team on this unit indicated that one of the key challenges in being open about their emotional experience appeared to be a concern that perhaps disclosing how they felt, be it pleasant or unpleasant emotional experiences, could be ‘misconstrued’ or ‘misunderstood.’ Perhaps at times it may feel safer for staff members to avoid sharing of thoughts and feelings for fear of judgement. We note that this feedback occurred in the presence of a ‘safe’ process on the unit that explicitly gives permission for such explorations. We wondered whether it might be useful to see staff reservations about disclosing emotional experience in this context as very similar to the overt avoidance of affect seen in many people with complex trauma in the face of active offers of support. In the writing of this article we have considered the potential parallel process between service user experience and staff team experience.

**Rewards of using a team formulation approach**

As stated above, on our unit we have been fortunate in setting up a team formulation model that has been supported and informed by the whole staff team, both nursing and support staff. We base our team formulation model on the core principles of attachment, in keeping with the model that underpins day-to-day care on the unit. We emphasise the importance of predictability and consistency (set time for the session each week), openness and attunement (everyone is encouraged to contribute and the facilitators remain open to the staff team interpretation rather than attempting to ‘provide’ their formulation), and the development of empathic understandings to underpin our work on the team. Overall, we aim to achieve a ‘safe and protected thinking space for the team’ (Lake, 2008).

With reference to the rewards of using team formulation, the key themes fell into three main categories; namely, a sense of being united as a team, recognising the importance of good communication, and gaining understanding.

One staff member reported feeling ‘positive to be able to talk openly’ and another member of the team referred to ‘feeling good when we’re all together and thinking’. Engaging in a formulation process appeared to foster feelings of becoming ‘united’ as a team. From an attachment perspective this appears to suggest that, through feelings of safety and security during sessions, staff members may feel more able to explore potentially difficult thoughts and feelings in relation to their work, and therefore the reflective capacity of the team is likely to become enhanced.

There was acknowledgement of the importance of fostering good communication
between members of the team. One staff member appeared to find value in ‘talking about difficult things that we don’t always know what or how to say but it doesn’t really matter’. Another team member commented on the sense of reward in noticing that ‘other people feel the same as me and we’re on the same page’. Development of reflection and a shared understanding of how the interpersonal environment directly impacts on behaviour is crucial to the everyday work of a mental health ward. During individual therapy, the therapist may develop an internal ‘observer’ to notice these complex relational dynamics rather than just engaging in action. However, the reality for the staff team is that they are often placed in positions of significant demands and as a result may have less capacity, time and space to develop reflection and awareness of their emotional experience. Opening up channels of communication through the use of a team formulation can allow for structured and supportive discussion about therapeutically relevant patterns and processes, and supports care planning and intervention from the perspective of core evidence-based and practice-based evidence approaches.

Some members of the team appreciated the development of understanding that may arise from team formulation sessions: ‘I have always wanted to understand what was happening and get better and knowing why people do what they do’. The process of supporting staff to have protected time and space to reflect on their emotional experience in relation to the service user with whom they work may feel validating in itself. However, members of the staff team also recognise the importance of developing understanding in order to inform ongoing care planning and intervention. Experientially, if the staff team feel supported in the understanding and reflection of complex dynamics and in considering alternative ways of relating, this can support them to avoid being drawn into ‘toxic’ or unhelpful patterns of attachment.

**How do we address dilemmas about true service user involvement in team formulation sessions within secure settings?**

Both nurses and psychologists have an understanding of the importance of shared collaboration in the development of care plans, formulations and interventions. Shared collaboration provides openness and empowers the service user to demonstrate that it is their prerogative to take the ‘driving seat’ in their own life. Of course, in the systems within which we work, true collaboration is often a challenge to achieve and service users can feel controlled or dictated to by the mental health system. Whilst considering how we could include a service user voice and perspective in our team formulation sessions, and for that matter in this article, we encountered a number of questions.

Firstly, we wondered how feasible it would be to take along collaborative formulations that had been developed with service user and psychologist and/or primary nurse and refer to them as part of the team formulation session without the service user present. With consent from the service user, this appears to be a potentially helpful process to enhance understanding and awareness of key patterns. However, upon further deliberation we wondered whether we were also restricting or minimising the service user’s voice and disempowering them in the process. Since considering this dilemma, we have explored and trialled sessions with the service user directly involved in team formulation.

Some service users openly voice a request for others to become involved in the formulation process to enhance others’ understanding of them and their difficulties. It is likely that when a service user feels understood, either within a psychology session or talk time with primary nurse/support workers, there is a desire for a transferring of understanding from these sessions into general understanding on the unit by all members of the team. As a result of these requests, we have supported the service users on the unit to take ownership of their formulation and to share this with the team. This occurs within smaller team formulation sessions where the service user takes a key role in voicing their understanding and engaging in team discussion to support the team’s understanding. Such sessions also integrate discussion and exploration of specific psychologically-based interventions and models.

Our experience has been a surprising one. As a team, we have reflected upon how we have at times felt surprised at the level of ownership
and responsibility taken by some service users in
the communication and sharing of their forma-
lutions and own understandings, particularly by
some who typically find it difficult to hold onto
a sense of responsibility and ownership of their
role in their own care pathway. We have seen
this as a reminder that we can all too easily fall
into an ‘expert’ stance where we can assume to
hold the understanding for ourselves as profes-
sionals, but forget the most important person in
the process. This process has reminded us of
the importance of ‘in the moment’ recognition
and validation when the service user demonstra-
tes their ability to hold ownership over their
own understanding. This potential trap is, inde-
pendent of theoretical model or discipline, that
without reflection and awareness we may all fall
victim to assuming that we ‘know’ more about
subjective experience than we actually do.

Secondly, we have also acknowledged the
importance of striking a balance between
helping service users and supporting staff to
help them. We have tried to enable and
empower the team to feel safe enough to
share their experiences so that they can pro-
vide thoughtful and considered interventions
whilst working with highly complex and some-
times hostile dynamics. It can be difficult to
provide a safe, reflective space for service
users if we ourselves do not feel understood or
thought about.

Reflection on our role in the team forma-
luation process, and the role of the people with
whom we work, has reminded us of the contin-
ual reflection that is needed if we are to
achieve collaborative practice in settings
where risk and accountability for its manage-
ment is a constant companion in our work.

Conclusion
The writing of this article has allowed us to
reconsider the practices we have become
accustomed to. We recognise that we have not
achieved formal service user involvement in
this article despite emphasising the importance
of service users’ voice in the team forma-
luation process. We are aware that there is a
balance to strike between the need of the staff
team to feel safe enough to express their emo-
tional experiences in their work alongside the
value of the service user being involved in dif-
ferent stages of the formulation process. The
formulation process can enhance reflective
capacity and support psychologically-informed
interventions within a system that often strug-
gles to remain reflective, for wholly under-
standable reasons.

Within such a complex system, individual
formulation work has its place, but we also
need to recognise the importance of working
systemically. We aim to return to our dilemmas
regarding true collaboration with service users
in the team formulation process and have
made plans to meet with service users from our
unit and invite them to comment and reflect
upon their experience of sharing and reflect-
ing upon formulations with their team.

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Denver: Oak Hill Ridge Press.
This article describes the development of a reflection tool to promote good practice for staff experienced in facilitating team formulation (regardless of model) and to support the development of staff new to this role.

Since 2007, clinical psychologists within mental health services for older people in Tees, Esk and Wear Valleys NHS Foundation Trust have worked hard to increase psychological thinking within teams. This has been predominantly achieved through the use of formulation in indirect practice, and specifically in the use of the Roseberry Park model (underpinned by cognitive behavioural therapy; Dexter-Smith, 2007). Now, over 500 staff from inpatient and community teams have been trained in an introduction to cognitive behavioural formulation, and regular formulation sessions are offered in each team (see Dexter-Smith, this issue for more information).

As part of this process we wanted to ensure that we were reflecting on our own and each others’ practice and supporting staff who were new to, but central to, the process (e.g. trainee applied psychologists and specialist clinical staff in intensive/care home liaison teams, who play a central role facilitating team formulations in the service). As the use of formulations within teams grew and the foundation of Roseberry Park formulation was built upon with cognitive analytic therapy reformulations in some teams and the Newcastle model in others, it became apparent that we needed a framework that would support the governance of the process of formulation regardless of the model utilised.

Jackman et al. (2013) highlighted gaps in the governance of indirect therapies and the lack of detailed consideration to date of the knowledge and skills required to facilitate a formulation session. This is despite the fact that the people requiring this level of psychological input are often experiencing the most complex situations, which in turn can present many challenges for the services that work with them. The authors argue that as most of our major therapy modalities impose strict regulation on those accredited to deliver them, equally close governance should apply to indirect therapies.

The British Psychological Society document Good Practice Guidelines on the Use of Psychological Formulation was a useful resource (DCP, 2011). It recognises the need for a skilled and sensitive approach in facilitation to ensure that the formulation is accepted in its wider systemic context. Kennedy (2009) acknowledges that an important task facing the psychologist at the start of a formulation session is to clarify who is attending, how to take all interests into account and what the likely consequences may be. It takes a skilled facilitator of formulation and groups to manage possible resistance within the team, differences in opinion and multiple dynamics. The DCP (2011) guidelines offer a checklist of good practice in the use of formulation, which is designed to support and evaluate psycholo-
gists within their clinical practice in relation to formulation, to aid supervision and appraisal, assess trainee psychologists in practice and check the quality of formulations.

Jackman et al. (2013) also developed the Formulation Strategies Score Sheet (FSSS) from video recordings of formulation sessions in care homes for older people facilitated by staff from the Northumberland County Challenging Behaviour Service. The score sheet is a simple checklist comprised of items reflecting the skills that were present in the recorded sessions. The FSSS was specifically designed to develop skills in delivering formulation sessions using the Newcastle Model (James, 2011) and the grid in the FSSS follows the general pattern of Newcastle Model formulation sessions. The FSSS had been used within one of our care home liaison teams for two years as a supervision tool to develop and assess competency and ensure some consistency in approach. New staff were invited to observe more experienced staff facilitating formulation sessions and to ‘score’ their supervisor’s performance in facilitating sessions using the FSSS. They were then asked to use the FSSS to assess their own level of competence and confidence, and were asked to bring parts of the model to supervision to improve their theoretical knowledge or their presentation skills through roleplay. Finally, the supervisor observed a full formulation session and ‘scored’ the supervisee.

However, as the FSSS follows the specific model used in that service so closely, we needed to adapt it so that we could support each others’ development in the different formulation model that we were using across our service, and also for staff who were doing more specialist formulations such as cognitive analytical therapy. Key parameters were that it must integrate the guidance from the DCP, be neutral regarding model, and support mutual observation for any staff facilitating a team formulation.

Feedback has been shared in order to promote the quality of team formulation.

Formulation Session Reflection Tool
The Formulation Session Reflection Tool created by the authors was developed in line with the DCP (2011) checklist and the FSSS (Jackman et al., 2013). It is reproduced at the end of this article. The ten sections are divided into individual questions to prompt the observer to consider in detail all the aspects of a formulation session.

So far, within the mental health services for older people specialty, all psychologists have mutually observed one another in the facilitation of their team formulation sessions. Feedback has been shared in order to promote shared learning and the quality of team formulation. The tool is also routinely used for trainee clinical psychologists within mental health services for older people, where the delivery of formulation sessions is a requirement of their placement. As yet, detailed feedback from staff members in utilising the tool has not been obtained; however, comments from staff have been positive.

As part of the governance of team formulation we have also been asked by the service’s senior operational team to specify who can and cannot facilitate a formulation session. In brief, the guidance is that staff at Band 5 and above (Agenda for Change) should have attended the service’s one-day introductory training, and with a clinician already deemed competent to facilitate, have also:

- Observed five team formulations.
- Carried out three formulation meetings.
- Been observed, using the Formulation Session Reflection Tool, with both observer and clinician agreeing that they are confident/competent to cover the different areas.

Although this guidance is relatively broad, the only non-psychology facilitators to date are nurses and occupational therapists from the intensive community liaison and care home liaison teams. This is because indirect formulation is a core element of the liaison team members’ job plans, whereas other staff face numerous competing demands in their primary role. It is hoped that in time, use of the tool will encourage more multidisciplinary
team members to feel confident in facilitating team formulation meetings.

We welcome use of the tool, as long as its origin is cited. We would be interested to hear feedback from anyone who employs it within their own service, and can be contacted at the e-mail addresses below.

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**The British Psychological Society**

**Division of Clinical Psychology**

**West Midlands Branch**

**DCP West Midlands Branch CPD Day & AGM**

**Adding Value: Leadership and Attachment in the NHS**

The Holiday Inn Birmingham City Centre, Smallbrook Queensway Birmingham B5 4EW

Tuesday 15 December, 9.00am–4.30pm

Keynote speakers:

Professor Dame Julie Moore on Clinical Leadership

Kim Golding on Attachment

Angela Busuttil on Clinical Psychology in Physical Health

The event will also include an update from the DCP, and afternoon workshops (including Professor Graham Stokes on Dementia) and a meeting of the West Midlands New and Recently Qualified Group of Clinical Psychologists

This is a free event open to DCP members only.

To book, go to:

### Figure 1: Formulation Session Reflection Tool

Name of facilitator..........................................................................................................................................

Name of observer..........................................................................................................................................

Date of observation......................................................................................................................................

1. **Introduction**

- Does the facilitator introduce him/herself and the model?
- Is the purpose of the session explained?
- What is the aim of the formulation?
- Where would the staff like to get to at the end?

2. **Presenting problems**

- Are the presenting problems (client’s and staff’s) clearly described?
- Does the facilitator elicit further information about patterns of thoughts, feelings and/or behaviours?
- Does the facilitator check information is correct?

3. **Personal information (life history, etc.)**

- Is the life history told chronologically (like a story)>
- Are links made between personal information and the formulation model?
- Is it explained to staff in a way that is meaningful and understandable?
- Are gaps in knowledge identified...
- What else do we need to know?
- Does the facilitator promote empathy?
  (e.g. ‘Can you imagine how it felt...?’)

Developed by S. Craven-Staines and J. Marshall based on the Formulation Strategies Score Sheet created by Jackman et al. (2013). Last Updated: April 2015, Copyright © Tees, Esk and Wear Valleys NHS Foundation Trust, 2015. You are welcome to use this tool freely if you cite the source.
### 4. Integration of knowledge and theory

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the formulation make sense of how difficulties may relate to one another?</td>
<td></td>
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<tr>
<td>Are patterns understood and linked through the life course?</td>
<td></td>
</tr>
<tr>
<td>How are difficulties being maintained?</td>
<td></td>
</tr>
<tr>
<td>Is the team (or any other system) playing a part in maintaining the difficulties?</td>
<td></td>
</tr>
</tbody>
</table>

### 5. Risk

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are risk issues clearly addressed and considered?</td>
<td></td>
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<tr>
<td>Is there a plan with regards to how they are going to be managed?</td>
<td></td>
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</tbody>
</table>

### 6. Strengths

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Are the client’s strengths/ protective factors considered?</td>
<td></td>
</tr>
<tr>
<td>Are ways to promote these strengths identified?</td>
<td></td>
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</tbody>
</table>

### 7. Guiding interventions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Are there clear links between the formulation and interventions?</td>
<td></td>
</tr>
<tr>
<td>Are interventions prioritised?</td>
<td></td>
</tr>
<tr>
<td>Are individuals identified to take a lead on the intervention?</td>
<td></td>
</tr>
<tr>
<td>Are current practices valued and reinforced if appropriate?</td>
<td></td>
</tr>
<tr>
<td>Are new ideas elicited from staff and the facilitator and valued?</td>
<td></td>
</tr>
<tr>
<td>Is structure given to new intervention plans?</td>
<td></td>
</tr>
<tr>
<td>Is the formulation going to be shared with the client? Who will do this?</td>
<td></td>
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<tr>
<td>Are potential responses to interventions and possible setbacks highlighted?</td>
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</tbody>
</table>

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### 8. Review

Has a review date and time been specified?

### 9. Process issues/Facilitating the formulation

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff views elicited?</td>
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<tr>
<td>Does the facilitator add new information to the template/flip chart while presenting?</td>
<td></td>
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<tr>
<td>Does the facilitator acknowledge staff contribution?</td>
<td></td>
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<tr>
<td>Is there active listening (nodding, eye contact etc.)?</td>
<td></td>
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<tr>
<td>Checking?</td>
<td></td>
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<tr>
<td>Are staff following session?</td>
<td></td>
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<tr>
<td>Is information accurate?</td>
<td></td>
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<tr>
<td>Does everyone agree?</td>
<td></td>
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<tr>
<td>Was it managed appropriately if not?</td>
<td></td>
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<tr>
<td>Does the facilitator direct discussion (e.g. bring people back to the point)?</td>
<td></td>
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<tr>
<td>Is humour used (if appropriate)?</td>
<td></td>
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<tr>
<td>Are there signs of collaborative language ('we' 'us')?</td>
<td></td>
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<tr>
<td>Does the facilitator sign-post (e.g. 'I'll come on to that next')?</td>
<td></td>
</tr>
<tr>
<td>Is there appropriate professional disclosure from the facilitator about their own experiences?</td>
<td></td>
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<tr>
<td>Does the facilitator share information gained from other professionals?</td>
<td></td>
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<tr>
<td>Are bridging statements used? ('So, we can see that... so let's look at how this would impact on...')</td>
<td></td>
</tr>
<tr>
<td>Are staff concerns validated and responses normalised?</td>
<td></td>
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<tr>
<td>Is information summarised?</td>
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</table>

### 10. Self reflection

How did the facilitator experience the formulation (i.e. did they reflect on anything that they would have done differently)?

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Developed by S. Craven-Staines and J. Marshall based on the Formulation Strategies Score Sheet created by Jackman et al. (2013). Last Updated: April 2015, Copyright © Tees, Esk and Wear Valleys NHS Foundation Trust, 2015. You are welcome to use this tool freely if you cite the source.
A LARGE SCALE PROJECT to integrate formulation into Sussex Partnership NHS Foundation Trust was described in Casares and Johnstone (this issue). One year after the initial training took place, an evaluation was carried out with the following aims:

- To investigate multidisciplinary staff knowledge of, and confidence in using, formulation one year after training.
- To gather information about individual staff members’ use of formulation in their clinical practice.
- To identify what progress teams as a whole have made in integrating formulation into their work.
- To find out what issues may present barriers to using formulation.

There were two parts to this evaluation: (i) a questionnaire e-mailed to attendees of the training, and (ii) semi-structured interviews with ‘formulation leads’ from each of the new locality bases across the Trust. Formulation leads in each team had overseen the roll-out of formulation in their locality and set up monthly practice development groups for this purpose.

Evaluation questionnaire
A questionnaire was developed in consultation with representatives of the Hastings Formulation Development Group (a group of multidisciplinary professionals), Dr Gillian Irving Quinn and Dr Philippa Casares. The questions covered staff knowledge and confidence in and use of formulation, both individually and within their team. There were 16 questions, including seven Likert scale items, six open-ended items and four multiple option items (three with open response spaces to report other factors). Two demographic items related to the respondent’s locality and professional role.

As this was a small-scale evaluation project and limited time was available, it was not possible to follow-up all workshop attendees (Workshop 1: n = 240; Workshop 2: n = 273). Therefore, convenience sampling using the attendance lists from the training days (n = 132) and attendees at a follow-up formulation workshop was used. A total of 31 completed questionnaires was received.

Interviews with formulation leads
Leads representing all nine locality teams (one assessment and treatment service (ATS) had divided into two services by this time) agreed to participate in semi-structured interviews of between 20 and 40 minutes.

The interview schedule comprised six items that focused on the team’s integration of formulation into their practice and any factors that were presenting barriers.

Ethical considerations
Written approval was obtained from the Trust for this project and to publish it here. Staff invited to participate were informed of the
Table 1: Thematic analysis findings.

<table>
<thead>
<tr>
<th>Theme label</th>
<th>Sub-themes</th>
<th>Theme definition</th>
<th>Total number of extracts on this theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evolving process</td>
<td>Implementing formulation within the teams as a gradual process through the year, during which various strategies had been tried</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promoting formulation, getting started and not putting people off</td>
<td>The start of the process had involved encouraging staff to try using formulation</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Increased awareness and talking more about formulation</td>
<td>Staff being more aware of formulation and it being referred to more often in conversation</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Learning through practice</td>
<td>Using formulation, particularly in team meetings, enabled staff to continue learning about formulation after the workshops</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Low confidence</td>
<td>Staff not having confidence in their ability to use formulation</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Keeping formulation on the agenda</td>
<td>Formulation had continued to be a focus for teams work when they kept discussing it as a team</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Further training</td>
<td>More training would help staff use formulation</td>
<td>14</td>
</tr>
<tr>
<td>Importance of structure</td>
<td>The use of formulation being supported by structures within the teams’ work</td>
<td>27</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Regular formulation meetings</td>
<td>Team meetings to discuss and develop a formulation about the teams' work with a service user</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Management support</td>
<td>Team managers supporting the use of formulation</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Structure in paperwork</td>
<td>Having paperwork with a format to guide formulation</td>
<td>4</td>
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</table>
Table 1: (contd.) Thematic analysis findings.

<table>
<thead>
<tr>
<th>Theme label</th>
<th>Sub-themes</th>
<th>Theme definition</th>
<th>Total number of extracts on this theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploring staff perspectives</td>
<td></td>
<td>Using formulation as a way to think about the teams’ work with service users and</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to make sense of staff experiences of the work</td>
<td></td>
</tr>
<tr>
<td>Complex clients and risk management</td>
<td></td>
<td>Using formulation to guide work with clients viewed by the team as complex and to</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>inform risk management</td>
<td></td>
</tr>
<tr>
<td>Individual use</td>
<td></td>
<td>Staff using formulation outside of the team meetings</td>
<td>17</td>
</tr>
<tr>
<td>Purpose</td>
<td></td>
<td>Understanding the reason for utilising formulation and viewing it as having a</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>meaningful aim</td>
<td></td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td>What formulation leads to</td>
<td>36</td>
</tr>
<tr>
<td>Expecting a different outcome</td>
<td></td>
<td>When staff or service users expected something different to result from completing</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a formulation</td>
<td></td>
</tr>
<tr>
<td>Sharing the formulation with the client</td>
<td></td>
<td>How a formulation developed within a team meeting is fed back to the service user</td>
<td>11</td>
</tr>
<tr>
<td>Routine team business or something extra</td>
<td></td>
<td>Whether it is an everyday component of teams' work or another task to have to</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>manage on top of other demands</td>
<td></td>
</tr>
<tr>
<td>Active involvement of multi-</td>
<td></td>
<td>An aim for teams of participation of the whole team, including in facilitating</td>
<td>32</td>
</tr>
<tr>
<td>disciplinary staff</td>
<td></td>
<td>meetings</td>
<td></td>
</tr>
<tr>
<td>Core business for psychology</td>
<td></td>
<td>Other professionals view it as the psychologists' job</td>
<td>47</td>
</tr>
<tr>
<td>Openness to formulation</td>
<td></td>
<td>How willing staff are to try formulation can impact on whether they use it</td>
<td>15</td>
</tr>
</tbody>
</table>
Table 1: (contd.) Thematic analysis findings.

<table>
<thead>
<tr>
<th>Theme label</th>
<th>Sub-themes</th>
<th>Theme definition</th>
<th>Total number of extracts on this theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time pressures</td>
<td>Need to value it to make time for it</td>
<td>Staff spending time formulating when they value the approach</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Space to think and discuss with colleagues</td>
<td>Formulation meetings as providing an opportunity for staff to work together</td>
<td>22</td>
</tr>
<tr>
<td>Getting people through the door</td>
<td></td>
<td>Engaging people in formulation to get them to try it</td>
<td>4</td>
</tr>
<tr>
<td>Change as a barrier</td>
<td></td>
<td>Locality team changes and staff changes as preventing formulation being implemented within the team</td>
<td>2</td>
</tr>
<tr>
<td>Large team sizes as a barrier</td>
<td></td>
<td>Discussion of formulations in a large group as difficult</td>
<td>6</td>
</tr>
<tr>
<td>Targets</td>
<td></td>
<td>Participants reported that the target for every service user to have a formulation was off-putting. They found it more helpful to begin with the people they felt stuck with and roll out formulation more gradually</td>
<td>3</td>
</tr>
</tbody>
</table>

Analysis

Quantitative data

The questionnaire responses were entered into a Microsoft Excel spreadsheet, which enabled bar graphs to be generated to illustrate the descriptive statistics.

Qualitative data

The interview transcripts and the text questionnaire responses were entered into the NVivo qualitative data analysis programme and thematic analysis of the data followed the procedure outlined by Braun and Clarke (2006).

Results

Questionnaire respondents represented all locality teams and a range of professions. Nurses (n = 5), occupational therapists (n = 4), a psychiatrist (n = 1), psychologists (n = 14), social workers (n = 3) and a support worker (n = 1) returned questionnaires. Three respondents did not state their role.

Thematic analysis of the interviews and open-ended questionnaire items identified seven main themes about the integration of
formulation into the teams: evolving process, importance of structure, exploring staff perspectives, outcomes, routine team business or something extra, time pressures, and getting people through the door.

The findings will be structured according to the evaluation aims, drawing on the relevant results from the questionnaires and thematic analysis. Theme titles are underlined within the text.

**Aim 1: To investigate multidisciplinary staff knowledge of and confidence in using formulation at one year follow up**

All questionnaire respondents regarded themselves as having at least some knowledge of, and confidence in use of, formulation at one year follow up, and the majority of respondents rated their knowledge as good or very good and were confident or very confident about using formulation.

The interview feedback suggest that confidence in using formulation had grown over the year for some staff. Additionally, it was reported that staff were talking much more about formulation:

‘I certainly hear the word quite a lot… sometimes in the context of “this is my formulation” and other times… “You know, it would be really good to have more of a formulation.”’

‘The training was fantastic and certainly really increased people’s awareness of it and their inclination to do it.’

However, in the thematic analysis a sub-theme of low confidence (within the theme ‘Evolving process’) indicated that several of the formulation leads believe confidence is still low for some team members. Although leads hope staff confidence will improve with practice, it was acknowledged that some team members were less willing to attend formulation meetings, which may have limited their opportunities to develop their confidence.

**Aim 2: To gather information about individual staff members’ use of formulation in their clinical practice**

At one year follow-up, all questionnaire respondents reported formulation was relevant to their work and 77 per cent \( (n = 24) \) cited it as very relevant. Figure 1 indicates that all respondents used formulation at least occasionally. The subtheme ‘Individual use’ captures the variation in how formulation is used, with some bringing cases to discuss at meetings and others formulating independently. A few respondents discussed the need for the purpose of formulation to be clear for it to be perceived as meaningful and useful. The most common use of formulation was at assessment (80 per cent), although over 68 per cent of respondents were also using it at risk assessment, in supervision and during treatment. The estimated proportion of service users having formulations was only ‘some’ or ‘unknown’ for 28 respondents (90 per cent).

<table>
<thead>
<tr>
<th>Point in development</th>
<th>Percentage of respondents rating knowledge as good or very good</th>
<th>Percentage of respondents rating confidence in using formulation as good or very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post ‘Formulation at Assessment’ training</td>
<td>80</td>
<td>65</td>
</tr>
<tr>
<td>Post ‘Formulation in Teams’ training</td>
<td>83</td>
<td>64</td>
</tr>
<tr>
<td>At one year follow up</td>
<td>71</td>
<td>77</td>
</tr>
</tbody>
</table>

**Table 2: Changes in knowledge about and confidence in use of formulation**
**Aim 3: To identify what progress teams as a whole have made in integrating formulation into their work**

At the point of training, in 2013, 40 per cent of the participants said that there was a formulation meeting available to them in their service. At one year follow-up, in 2014, 90 per cent said there was now a meeting they could attend. Only one of the formulation leads said that they had not yet set up such a meeting in their team.

The interview feedback suggests that some team members were making more use of team formulation than individual formulation:

- ‘It’s been more workable for people to formulate around a case causing the team as a whole a lot of anxiety and pressure and concern.’

- ‘…priority to formulate may be driven by pressure to discharge someone or feeling overwhelmed …’

- ‘…they might come more when they’ve got a client they are worried about or that they want a team consensus around…’

- ‘I think it just needs to be around, I mean people do say, “Oh, we need a formulation” sometimes. So I think it is getting in there.’

Figure 2 shows questionnaire respondents’ estimation of the importance of formulation to their teams and illustrates that it was reported to be at least fairly important to most participants’ teams.

Many of the formulation leads described the implementation of formulation as having changed over the course of the year, as reflected in the theme ‘Evolving process’. This process had involved the successful integration of formulation into some ways of working, such as the regular formulation meetings. Some teams had also tried to incorporate formulation timeslots within multipurpose team meetings and this was discontinued as it was not perceived as helpful. Two subthemes relate to the initial stages of the process during which it was reported there has been an ‘increased awareness’ of formulation developed within the teams and team members have been ‘talking more about formulation’:

Figure 1: Bar graph of responses to question five: ‘To what extent do you currently use formulation in your clinical practice?’
Integration of formulation in adult multidisciplinary services

It was clear that the formulation leads had worked extremely hard to keep the formulation work alive by ‘promoting formulation’ and ‘getting it started and not putting people off’.

‘My feeling is that nobody’s wanted to put people off and … [they] wanted to find a way of encouraging people to just get going [with formulation].’

‘Not putting people off’ was a key issue, largely because leads were aware of the pressures staff had already been put under, with the whole service changes, and did not want to burden them with more demands on their time.

The respondents’ suggestions about how to further develop formulation covered many of the ideas suggested in 2013. Three sub-themes indicate the ideas formulation leads had for future developments by ‘learning through practice’, ‘keeping formulation on the agenda’ and ‘further training’. Several of the leads reported that staff were developing their skills in formulation by coming to the team meetings and presenting their cases. As had been found in 2013 following the workshops, some respondents in 2014 also wanted further training or regular workshops. It was suggested that training on writing up formulations would be particularly helpful.

The theme of the ‘importance of structure’ was present in many responses. ‘Regular formulation meetings’, at weekly or fortnightly intervals, were helpful in enabling teams to think together about their service users and integrating formulation into their work:

‘The original workshops certainly galvanised people into considering how best to use formulation and I think what happened is, is that formulation was then formalised.’

‘Structure in paperwork’, with prompts to guide the development of a formulation or a template to structure the formulation within a specific model, was seen as helpful, particularly when the process was new to teams. Some leads spoke about using the same model to enable staff to become confident in using one approach, although the model used varied between local teams. The models mentioned included the Five Ps approach (Weerasekera,

Figure 2. Bar graph of responses to question 10: ‘Currently, how important is formulation to your team?’
1996), cognitive behavioural diagrammatic models, and Lake’s team formulation approach (Lake, 2008):

‘I think it helps people to have a very straightforward, simple format to follow.’

‘Management support’, which had been a key focus of the original project and a suggestion in 2013 about how to increase confidence in using formulation, was identified at follow-up as crucial to ongoing development:

‘One thing that does feel like it’s been helpful for us is I do feel that we have management support.’

‘It did go from strength to strength and it got supported by the team leads, the managers, and it felt like a whole team approach.’

Although all formulation leads mentioned the time pressures as a key challenge for teams, several also expressed the view that formulation was a valuable opportunity for staff to access a reflective space within demanding work environments.

**Aim 4: To find out what issues may present barriers to using formulation**

The main barriers identified by the leads were: time pressures, change within the teams, including their larger size, whether formulation is seen as a role for psychologists or the multidisciplinary team, and formulation not leading to clear outcomes.

**Time pressures:** A key issue voiced many times as preventing formulation even when teams wanted to use it was the immense time pressure that teams face. ‘Time’ was the most popular questionnaire response to what would enable greater use of formulation (n = 23, 74 per cent):

‘One of the barriers we identified was that people, you know, just felt like they had so much to do, coming in; typing up their formulation would just be another thing.’

Formulation leads from localities that had the active involvement of multidisciplinary professionals in meetings reported that this was achieved by involving them in facilitation, rather than just inviting them to attend. One of the aims of the formulation project was to introduce formulation skills to the whole multidisciplinary team and ensure that it became central to the new way of working. The multidisciplinary team training was highly valued, and the leads clearly worked hard to ensure there was full sign-up and involvement. This was achieved to varying degrees and is an on-going piece of work:

‘We also wanted to get other professions on board in facilitating as well, but it’s been quite hard to do.’

‘Co-facilitated, originally co-facilitated by a nurse and a team leader, now one of the psychiatrists has been doing it.’

Contributing factors to this are highlighted by the subthemes of ‘Change as a barrier’ and ‘Large team sizes as a barrier’:

‘One of the real challenges about setting up the formulations is getting people there – you know, that’s the biggest hurdle, getting people in the door.’

Formulation by psychology or the MDT team: Variation in how formulation was received by the teams is reflected in the theme ‘Routine team business or something extra’. One aspect of this is reflected in the subtheme ‘Core business for psychology’. Interviewees frequently commented that formulation is perceived by psychologists and other professionals as something that psychology has time to do, should be doing and should be leading, and is not part of other professionals’ core role:

‘I think people don’t feel that it’s their core business in the way that it does for [psychologists].’

‘There’s a sense of it feeling it’s something on top of, you know, what we would be doing anyway.’

In addition to time, ‘getting people through the door’ was seen by one lead as a challenge.
Several people linked team ‘openness to formulation’ with how much a team incorporates formulation into everyday clinical practice. Four participants described their team as open to this approach, but a couple mentioned unwillingness or that team openness was not being followed through to action.

**Formulation not leading to a plan for intervention:** There were differing practices within the teams in relation to the theme of ‘outcomes’. A couple of participants spoke about the helpfulness of having a clear plan devised from the formulation. However, several interviewees mentioned that the formulations are not always written up, and thus if attendees or clients were ‘expecting a different outcome’ from the formulation, they may be disappointed. ‘Sharing the formulation with the client’ after a team formulation meeting in the most helpful way was mentioned by a few leads as something they have been reflecting on. In one area service users are sometimes invited to small formulation meetings, facilitated by a psychologist and including the other professionals involved in the individual’s care.

**Discussion**

Overall, these findings indicate that the project has had some success in starting to integrate formulation into the new service structures. It is clearly now on the agenda for all the new assessment and treatment services, and there is now widespread awareness of this approach within teams. All of those surveyed viewed formulation as relevant to their work, many reported good levels of knowledge and all had used formulation at some point.

However, training in itself is rarely enough to achieve full integration of a new approach, which is why formulation leads were selected within each of the new teams. These leads have created practice development groups to support the integration of this work into everyday practice. All but one of the localities now implement a regular team formulation meeting (ranging from weekly to monthly) and the remaining team plans to introduce one. Individuals with a particular interest in formulation have been working hard to encourage their colleagues’ and the team’s overall openness to this approach. However, it has been challenging for most of the teams to sustain progress and move from formulation being seen as an extra, to integrating it as a routine part of their work.

Although many staff saw formulation as central to psychologists’ work, there was enthusiasm for a multidisciplinary approach to formulating. In one team, meetings are co-facilitated by a psychologist and another professional. Having the experience of different team members valued and contributing equally in developing formulations has previously been found to be appreciated by staff (Hollingworth & Johnstone, 2014).

The evaluation suggests that teams have found formulation particularly useful in helping them to understand complex clients and to support risk management (Wilcox, 2013; Hollingworth & Johnstone, 2014). Having a structure for formulations and the opportunity to think and discuss with colleagues was highly valued, which reflects previous findings (Summers, 2006).

Embedding formulation into secondary care mental health services at a time of great change was an ambitious project. Certainly there are pros and cons of trying to introduce a new way of thinking when everything else is changing and staff are under enormous pressure. As time has gone on we have realised that although we would still want all service users to have care plans that are informed by a formulation, we may need to work towards this in stages. An initial focus on more complex service users was suggested by some of the leads as a way to introduce formulation in a way that would be of most benefit to the teams.

Some leads reported that staff members or service users had been disappointed when the formulation meeting did not lead to an action plan or practical changes, despite the fact that the core purpose of formulation (DCP, 2011) is to inform the intervention. Working out how to share formulations with clients was described as challenging. This needs careful consideration, as there is some evidence that clients can find written formulations distress-
Limitations

One of the main limitations of this project is that the staff who chose to participate are likely to have an interest in formulation. Fifty per cent of questionnaire respondents were psychologists and most of the formulation leads were also psychologists. This probably indicates that this professional group is still taking the lead in promoting the use of formulation within their teams, which is consistent with other project findings (Dexter-Smith, 2010). Furthermore, as formulation leads who had been tasked with promoting formulation also participated in this evaluation, they may have been more willing to share successes of the project than its challenges.

The full range of views within the teams may not have been represented in the small number of completed questionnaires returned. In total, 240 staff attended Workshop 1; 273 attended Workshop 2 (61 per cent of Workshop 2 attendees had attended the first workshop); and 31 follow-up questionnaires were received. Additionally, as the questionnaires were returned anonymously, it is possible that some formulation leads may have responded via both the questionnaire and interview.

Authors

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References


Staff experiences of formulating within a team setting

Shreena N. Unadkat, Gillian Irving Quinn, Fergal Jones & Philippa Casares

This study evaluates psychology-led formulation sessions within an assessment and treatment service. Five staff members completed interviews exploring their experiences of formulation and their perception of its usefulness to clients. Results suggested that they perceived formulation to be beneficial on a number of levels for themselves and their practice but were uncertain about the tangible benefits for clients.

As part of a major service re-organisation, Sussex Partnership Trust set up a project to integrate formulation within all its assessment and treatment teams (Casares & Johnstone, this issue). Formulation leads in each locality were encouraged to set up regular team formulation meetings to allow multidisciplinary discussion of complex or longer-term service users. To date, eight of the assessment and treatment services have implemented such meetings, and the remaining one is about to do so. This service evaluation investigates staff experiences of the formulation meetings within one team. An exploratory, qualitative stance was taken. The aims were to discover:

1. What were the main staff motivations for bringing a client to formulation?
2. How did staff members experience the sessions?
3. What influence did staff perceive formulation to have on their practice and clients?

Method

Participants

Participants were staff members in a newly formed secondary care adult mental health community assessment and treatment service, who had attended at least one formulation session in the preceding six months. They were recruited via information sheets, distributed and explained at a clinical team meeting. Five staff members responded to the invitation to participate out of a pool of fifteen potential participants. Of the five, four were female and one was male, and all were of white British ethnicity. The group comprised of two community psychiatric nurses, two occupational therapists and one support worker. Age and socioeconomic data were not collected.

Design

The study used a qualitative design with semi-structured interviews. Interviews began with general questions about how the participants found the meetings. Further questions were developed based on the ‘Purposes of a formulation’ section of the Division of Clinical Psychology’s Good Practice Guidelines on the Use of Psychological Formulation (2011, p.8). Questions were left open in order to allow both positive and negative answers. Participants were also asked about areas that formulation meetings missed and ways in which the process could be improved. Prior to the main data collection, the interview schedule was piloted on two team members to check face validity. Feedback led to adjustments to the wording of the questions to ensure openness and good coverage of potential effects of the sessions on client working.

Procedure

Participants were informed that the study was fully anonymised and that data recorded would be stored securely. It was made explicit that participation was voluntary and informed consent was sought. Face-to-face interviews were carried out by the first author and recorded on a digital recorder. Partici-
pants were asked to focus on one client that they had discussed at a formulation session. The interviews were transcribed and the researcher analysed the data using thematic analysis (Braun & Clarke, 2006). Themes were cross-checked by the second and third authors for validity.

**Results**

The seven main themes are described under the headings below, along with twenty-one subthemes, which are indicated in bold.

**Wanting a way out of frustration and being stuck**

Participants described feeling a sense of difficulty about their work with the client before taking the decision to attend a formulation meeting. Every participant reported themselves, the client or the team as feeling ‘stuck’. This was described in terms of a ‘...lack of change’, a feeling of ‘...not knowing what to do’ or of ‘...going round in circles’.

The majority of participants also reported feeling frustrated about their progress or work: ‘A definite sense of frustration about the situation, about where it was going’. Complexity of the client or client group was another theme. All participants noted the complexity of the clients’ presentation, history or relationship with the service: ‘We deal with very complex clients here.’

The majority of participants expressed a hope that the formulation session would relieve these ‘stuck’ feelings and promote change. Participants stated: ‘I’d hoped to find some clarity, I think; just a sort of way forward’ and ‘...there was a hope, I guess, that going along [to the formulation meeting] would help to relieve some of the stuckness I was feeling’.

**Validation and affirmation**

All participants expressed a positive sense of reassurance and recognition from the formulation sessions. This included a sense of validation of difficult feelings around their clients. This was described in various ways, such as: ‘...[formulation] made me feel like I wasn’t useless, or doing something wrong for feeling so frustrated’, ‘...it’s validating that... you are doing all right, that you are ok at this’.

Participants also expressed a sense of affirmation of the work that they were carrying out, commenting that: ‘...just to hear them say “actually I would probably be doing the same” is affirming and useful’ and ‘...when I was explaining it all to [the psychologist] I actually realised it did make sense really’.

There was also mention of a growing recognition of the service and one’s own limitations. Participants reported that ‘...sometimes it’s also about having someone not just say what had already been tried, but also what we couldn’t try anymore of’ and ‘...it was a much firmer stance than I expected from a psychologist, for them to say “actually, maybe they don’t need to know that, maybe it’s not good for them to have that”’.

**Stopping and thinking**

Participants reported a sense of slowing down of their thinking, describing ‘...a real shift, from reacting to reflecting’. This was noted as a distinct process from usual team practice: ‘Things can get quite rushed around here, so having that space to slow things right down took some getting used to. I think it was good in the end.’

Participants described the difference between the solution-focused approach of the team and the exploratory nature of formulation. This solution versus exploration was seen as useful aspect of the sessions: ‘I think we all naturally rush around to get a solution, you know, and I’m not sure that is always the best thing. We can forget to really think about things.’

**Getting a different perspective**

Another theme was of having an alternative perspective on the client’s issues, aided by an objective outsider. The theme of an external perspective was common, with participants stating: ‘...to get an external perspective, an objective one. That was helpful.’ And: ‘...when you’ve known someone for a long time, you get stuck asking the same sorts of questions in the same sorts of patterns. Sometimes it takes an extra person outside of it to really look for things’.

All participants commented on the placing of the client within the wider context of their
lives, histories, and their relationships with the team. Similarly, staff were encouraged to think about themselves in the wider context, with one participant noting ‘...it does just help to put the whole thing in context really, looking at it all as part of the system [we] are all a part of.’

Participants also discussed the benefit of having multiple viewpoints in the room and thinking from a multidisciplinary angle more effectively: ‘Just being able to hear from different disciplines, that helped to mix things up a bit.’ An additional reported benefit was the ability to share the case with the team (either by sharing risk burden or knowledge of the client). One participant stated: ‘I was managing the risk alone every time I saw the client, so sharing that with the team became a good process for me.’

**Increased understanding**

All participants reported an increased understanding of their clients’ issues. This was often expressed as a ‘...deeper and more thorough’ understanding of how the client’s history ‘...linked to the way they are presenting right now’.

The formulation sessions also highlighted gaps in understanding. The sessions ‘...showed us what we didn’t know really’ and ‘...left [me] with more questions than answers’. This prompted the staff member to seek out further information.

**Having protected time**

The theme of ‘time’ was apparent. All participants referenced the idea of having ‘protected’ or ‘ring fenced’ time as one of the most ‘...useful things about... formulation sessions’. One participant stated: ‘It’s a good development in the service, using some protected time to think this way.’ Formulation meetings were seen as a different use of time to the everyday practice of the team: ‘It’s a really different use of time. In our other meetings we go through things quickly and have a lot to cover.’

**Impact on clinical practice**

The majority of participants felt that they gained new strategies to work with the client, stating: ‘...it gave me a bit of a different way of looking at him after that; I guess I approached him differently’; ‘...there was a new strategy in my head, I suppose, more than anything’; and ‘...we came up with lots of new ideas about the client as a whole, lots of new ideas that were generated changed the way I thought about it.’

Some participants also commented on the passing on of validation, ideas, and containment to the client. One staff member stated that: ‘...it’s easier to be honest with clients and to contain them’.

Although participants noted new strategies and the passing on of benefits to clients, they struggled to name these when asked explicitly about the direct benefit to clients: ‘I suppose we might have thought about it differently, but overall things stayed much the same’; ‘I didn’t change a huge amount about the way I was working with the client – although I did refer them on’; and ‘It didn’t change the client’s pathway after the session.’ One participant also expressed dissatisfaction with the lack of a clear action plan at the end of the session, noting that: ‘I normally get a decision by the end of the meeting.’

**Discussion**

Overall, staff gave overwhelmingly positive feedback about their experience of formulation meetings. The main perceived benefits seemed to be the recognition and validation of their work, the opportunity to slow down and think about clients in a deeper way, and increased understanding of the clients’ issues. Although staff reported that they had new ideas and strategies to try, they struggled to identify more tangible benefits for the clients and impact on practice. This may reflect the very ‘stuck’ nature of the clients whom staff chose to discuss, or perhaps a hope that formulation would resolve the challenging issues with which they were faced. The comments may indicate a need for concrete action plans at the end of meetings or further meetings in which staff can identify progress and change in practice.

The results support guidance on the purpose and uses of formulation as described in the *Good Practice Guidelines on the Use of Psy-
Psychological Formulation (DCP, 2011). The themes are consistent with reported benefits such as noticing gaps in knowledge, troubleshooting, helping the staff member to feel contained, helping staff to manage risk, increasing team understanding, empathy and reflectiveness, drawing on and valuing the expertise of all team members, gathering key information, and raising staff morale. The findings are also in line with the results of another recent evaluation of staff experiences of formulation meetings (Hollingworth & Johnstone, 2014).

The data suggest that keeping protected time around formulation meetings is of great importance, as this provides the space and ability to think and react in a different way. Providing containment, validation and peer support may in the longer term help to protect against the ‘burnout’ that is common in secondary care mental health staff (Prosser et al., 1999), which ultimately leads to poorer treatment outcomes for clients (Lasalvia et al., 2009). Further research into this is needed.

Limitations of study
Participants were aware that the interviewer was a psychologist and that the results would be fed back to the psychologists who facilitated the formulation meetings. They may have withheld negative feedback for this reason. Questions were left open to allow for negative feedback; however, this was not specifically asked about. The sample size for the interviews was small, and participants were self-selecting and may have been those who felt most positively about the meetings. Further questions might have helped to ascertain whether positive effects were due to formulation specifically, or due to the general space for discussion. Qualitative methodology recognises that the researcher’s own values and biases may affect the research (Ratner, 2002). These issues were discussed in supervision prior to interviewing as a measure to reduce this risk.

Implications for future research
This service evaluation took an exploratory stance. The themes identified would benefit from further exploration: specifically, the perceptions staff have of how formulation influences their practice and client outcomes. A larger scale study may be able to test the presence of these themes in practice, and may wish to relate them to staff satisfaction and client outcome.

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